DOCUMENT RESUME

ED 402 050 PS 024 820

TITLE	The Impact of War on Child Health in the Countries of the Former Yugoslavia. A Report of a Workshop (Trieste, Italy, March 27-30, 1994).
INSTITUTION	Institute of Medicine (NAS), Washington, D.C.; National Academy of Sciences, Washington, D.C.
SPONS AGENCY	Ford Foundation, New York, N.Y.; John D. and Catherine T. MacArthur Foundation, Chicago, IL.
PUB DATE	95
NOTE	80p.
AVAILABLE FROM	Institute of Medicine, 2101 Constitution Avenue, N.W., Washington, DC 20418.
PUB TYPE	Collected Works - Conference Proceedings (021)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Adolescents; *Child Health; Children; *Child Welfare; Community Health Services; Coping; Disease Control; Emotional Response; Family Health; Foreign Countries; *Health Conditions; *Health Needs; Health Programs; Injuries; Mental Health; Physical Health; *Physicians; Primary Health Care; Violence; *War
IDENTIFIERS	Bosnia and Herzegovina; Croatia; Macedonia; Serbia; Slovenia; Traumas; *Yugoslavia

ABSTRACT

The wars that began in 1991 in the countries of the former Yugoslavia caused widespread child suffering. This workshop report presents the findings from the Workshop on the Impact of War on Child Health held for doctors from Bosnia-Herzegovina, Croatia, Macedonia, Serbia, and Slovenia. The workshop's goal was to address the common interest in the health and welfare of children by focusing on the state of child health and well-being in these countries which have experienced the political, economic, social, and physical devastation of war. The first section of this summary reports on the workshop study areas. For each country, the following are discussed: (1) epidemiology and getting information on child health in wartime conditions; (2) primary health care; (3) preventive medicine; (4) infant and child mortality; (5) trauma; (6) acute and chronic illnesses; (7) mental health, and; (8) child protection. The second section presents 49 specific findings in general care, epidemiology, primary health care, trauma, acute and chronic illness, mental health, child protection, and professional development. The third section describes the need for a network of health professionals whose aim is to improve the health and welfare of the children affected. Four appendices list advisors to the organizing committee, invited participants, organizational summaries, and the international convention on the rights of the child, including a summary of main provisions. (SD)

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The Impact of War on Child Health in the Countries of the Former Yugoslavia

A Workshop Summary

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The Impact of War on Child Health in the Countries of the Former Yugoslavia

A Report of a Workshop
March 27–30, 1994
Trieste, Italy

INSTITUTE OF MEDICINE

In Collaboration with the Office of International Affairs
NATIONAL RESEARCH COUNCIL

NATIONAL ACADEMY PRESS
Washington, D.C. 1995

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Institute of Medicine
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The serpent has been a symbol of long life, healing, and knowledge among almost all cultures and religions since the beginning of recorded history. The image adopted as a logotype by the Institute of Medicine is based on a relief carving from ancient Greece, now held by the Staatlichemusseen in Berlin.

COMMITTEE ON THE IMPACT OF WAR ON CHILD HEALTH IN THE COUNTRIES OF THE FORMER YUGOSLAVIA

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Preface

The wars that began in 1991 in the countries of the former Yugoslavia have horrified the world. Yugoslavia, a once reasonably affluent country with Western medicine and good standards of child health, was being destroyed in some of the most brutal ways imaginable, and children were suffering greatly. And yet it seemed that no one was capable of intervening.

The idea of the workshop described here began in April 1993, during a visit of scientists to Croatia and Slovenia under the auspices of the U.S. National Academy of Sciences (National Research Council, 1993). On that occasion I spent a pleasant day on the Adriatic Sea with several marine scientists from Slovenia, Croatia, and the United States. These scientists were old friends and colleagues who had not met since the war began, but on that sunny day they seemed perfectly happy and able to discuss oceanography and science together. The thought arose that professional concerns should be strong enough to transcend politics and the horrors of war. If marine scientists could meet in this way, why couldn't pediatricians meet to discuss child health and devise plans to remedy the terrible situation for children in many parts of the former Yugoslavia? Furthermore, why couldn't pediatricians reestablish their professional ties and invoke existing codes of professional ethics and international instruments such as the Convention on the Rights of the Child to protect children?

The project, which came to be known as the Workshop on Child Health, was convened by the Institute of Medicine in collaboration with the Office of International Affairs of the National Research Council, with additional support from the Ford Foundation, the John D. and Catherine T. MacArthur Foundation, the Soros Humanitarian Foundation, and Ross Products Division of Abbott Laboratories. The members of the organizing committee included senior

representatives of the U.S. academic pediatric community, the American Academy of Pediatrics, the International Pediatric Association, and the Union of National European Pediatric Societies and Associations. Invited participants from the countries of the former Yugoslavia included leaders in child health from their respective countries as well as physicians who knew and could speak about conditions of child health. These participants were chosen as individuals who might have the power to effect change in their own areas.

Trieste was chosen as the site for the workshop because it is a neutral territory to which all participants could travel and because it was relatively close to the countries of the former Yugoslavia. Nonetheless, the journeys involved were often long and circuitous because of disruption of travel routes by the war. For example, participants from Bosnia-Herzegovina waited for military flights to take them from Sarajevo to Ancona, Italy, and then embarked on a 17-hour train trip with numerous changes to reach Trieste. Many participants had not left their countries since the war began 2 or 3 years before, and some had had few days off since that time. Some, particularly our colleagues from Bosnia-Herzegovina, were noticeably thin and gaunt because of the circumstances under which they had been working and living.

We all arrived, alone or in small groups, on Saturday or Sunday, March 26 or 27, 1994, at a small hotel perched on a hilltop outside Trieste overlooking the Adriatic Sea. None of us of the organizing committee was entirely sure that the invited participants would actually arrive, or that if they did that the workshop could be maintained or that we could really stay together and talk for 4 days.

The first official gathering was a reception and a dinner on Sunday, March 27. As the sun was sinking beyond the low mountains over the Adriatic Sea, we all sat down together, somewhat tensely, around a single large banquet table. Midway through the dinner, we began with welcoming remarks from the U.S. National Academy of Sciences and Institute of Medicine (James Wyngaarden), the International Pediatric Association (Robert Haggerty), the Union of National European Pediatric Societies and Associations (Eberhardt Schmidt), and the American Academy of Pediatrics (Birt Harvey). Then I gave the following welcoming statement on behalf of the organizing committee:

> My Friends and Colleagues in Child Health: We of the organizing committee are very happy to greet you here tonight at this Workshop on Child Health. We are both honored and delighted that each and every one of you has been able to come, and we bid everyone a warm welcome!
>
> Why are we here? We of the organizing committee are pediatricians and professionals devoted to children's health. We care deeply about child health, we care deeply about our profession and its standards, and we care deeply about you, our professional colleagues. We feel that children everywhere are the proper concern of pediatricians everywhere and that we must all pull together as professionals to help each other and the children whom we serve.

We hope that this workshop will result in better health for the children of your countries and that, through sharing what we learn here, will result in better health for other children of the world as well. And we also hope that this workshop will result in professional friendships and bonds which will make us all feel part of the world community of pediatricians and children's doctors.

In beginning this workshop, we feel that we must acknowledge the horrors and the hostilities and the bitterness of the wars that have beset your countries in recent years. In the cause of child health and of our common professions, we beg you to view this workshop as a moment in time to put these feelings aside and to work together for children and their health. We are all doctors here, and we all share common professional bonds. In this present reality of the horror of war, someone in this world must find the strength and the wisdom to transcend the horror, to rise above the bitterness, and to allow inherent human decency to shine through and guide us all to a better future.

Let that someone be each of us here, and let this workshop reflect the mood of the future and not of the past. In the common spirit of our professions, let us talk here about all of our children and about what we can do to help them find better health and better futures.

And so may we toast:

> The health of all of our children.
> Our common professions and the ideals for which they stand.
> All of us here tonight and all of us everywhere who work for children.
> And finally,
> A better world for all of us and for all of our children.

Following these toasts, we asked each person present to rise and introduce himself or herself. The ice was already breaking, but it really melted when the head trauma surgeon from Sarajevo stood up—a man who had had only 3 days off in the last 2 years and who had been working under terribly difficult circumstances. He introduced his 15-year-old son, a refugee in Italy whom he had not seen for 2 years until that day. Barriers dissolved, and people began to tell of their own children and grandchildren, and their own lives. Onetime colleagues greeted each other across the table, and although people hinted at the suffering they had seen and experienced, they also affirmed their hopes for the future. Many of their comments were indeed heartwarming, and nearly all were collegial: "It is good to see old friends again." "We have not seen you for a long time." "We must all remember that what has happened to some of us could happen to any of us."

The spirit of the workshop was established that night. The next morning we gathered around a single conference table and began 3 days of sessions that were truly extraordinary in the attentiveness, the hard work, and the generally good

humor with which the workshop proceeded. There were few formal presentations, but there was much discussion guided by members of the organizing committee who served as chairs of topical sessions.

Throughout the workshop there were many moving and meaningful descriptions of what happens to children in wartime. Unfortunately, the participants from former Yugoslavia have had many firsthand experiences in the past 3 years. Their presentations made all of these problems come alive in a vivid way. The organizing committee expressed a deep debt to the participants who have been almost literally in the trenches and who were willing to share their experiences with us. Many indicated that we have been facing a crisis of values in our societies in terms of how to resolve conflict, and that when conflict breaks out we do not consider enough what this does to the lives and futures of children. Our hope is that this report will bring due consideration to what war has done to the health of children in this part of the world and that this knowledge will focus attention on protection of the health of children in difficult circumstances around the world.

Jane Green Schaller, M.D.
Chairman

Acknowledgments

The logistics of the workshop were difficult, to say the least. The United Nations Children's Fund offices in the countries of the former Yugoslavia were of great assistance in helping with communications, appropriate documents, and travel. We are particularly grateful to Thomas McDermott, the special representative from UNICEF to the former Yugoslavia, and Michel Duprat, the UNICEF physician in the former Yugoslavia, who regularly visits all of the regions. We also thank Sergio Nordio and Mario Andolina for assistance with arrangements in Trieste. The project staff, Joseph Cassells, Rosemary Chalk, Stephen Deets, James Carroll, and Julia Chill, provided valuable support with the administrative, rapporteur, and production tasks associated with the management of the workshop and the development of the final report.

Participants at the Workshop on Child Health, March 29, 1994, Trieste, Italy. Seated (left to right): Kulenovic and son (Sarajevo), Chill (Washington, D.C.), Avery (Boston), Ivanoska (Skopje), Schaller (Boston), Kos (Ljubljana), Vucak (Zenica), Nightingale (Washington, D.C.), Ispanovic (Belgrade), Begolli (Pristina), and Deets (Washington, D.C.). Standing (left to right): Harvey (Palo Alto), Carroll (Boston), Nordio (Trieste), Krzisnik (Ljubljana), Strbac (Knin), Sofianov (Skopje), Cassells (Washington, D.C.), Schmidt (Dusseldorf), Lolic (Banja Luka), Soce (Mostar), Haggerty (Rochester), Jamakosmanovic (Tuzla), Duprat (UNICEF), interpreter, Andersson (Botswana), interpreter, Haller (Baltimore), Katz (Durham), Krstic (Novi Sad), Ceric (Sarajevo), Parry-Jones (Glasgow), Wyngaarden (Washington, D.C.), Andolina (Trieste), Richmond (Boston), and Radonjic (Belgrade). Not pictured: Banicevic (Belgrade), Fattorini (Zagreb), Grguric (Zagreb), Kuhar (Ljubljana), and Verhellen (Ghent).

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The Impact of War on Child Health in the Countries of the Former Yugoslavia

Executive Summary

The participants in the Workshop on the Impact of War on Child Health in the Countries of the Former Yugoslavia (the "Child Health Workshop") were doctors from Bosnia-Herzegovina, Croatia, Macedonia, Serbia, and Slovenia, all of whom were knowledgeable about the situation of children in their own countries, and senior U.S. and European pediatricians drawn from academic and professional organizations. A common interest in the health and welfare of children provided the opportunity to put aside political differences in the interest of focusing on the state of child health and well-being in these countries that have experienced the political, economic, and social disruptions of war.

The presentations and deliberations of the workshop participants provided insight into currently available information to assess the physical and mental health of the children in these countries. Workshop discussions identified gaps in knowledge that can be addressed by future studies and professional exchanges in the areas of epidemiology, primary care, trauma, acute and chronic illnesses, mental health, and child protection.

The role of doctors as a conscience of the community deserves more consideration in times of stress and under difficult circumstances such as war. Pediatricians and children's doctors in particular have a professional obligation to act to protect children under such circumstances. Workshop discussions identified some key principles that can be used to guide professional practice in the protection of children. These principles include the need to keep children with their parents whenever possible, the need to protect children within their home communities whenever possible, and the importance of maintaining basic health, education, and social services for children under conditions of adversity.

In addition, workshop participants discussed codes of professional ethics and international guidelines such as the International Convention on the Rights of the

Child. There was consensus that such guidelines and international agreements constitute valuable instruments that can exert a powerful influence for the protection of children during times of turmoil. Improved communications between international and professional organizations such as pediatric societies were emphasized as important tools in achieving child protection and maintaining child health. The successful development of professional networks for sharing information and collaborations can be especially helpful to health professionals who are isolated both geographically and professionally under conditions of war and dislocation.

Participants in the Workshop on Child Health will reconvene at future dates to continue to develop communications networks, to sustain the relationships and exchanges that occurred during the discussions, and to move forward with specific projects such as the fostering of pediatric societies and their ties to the European and world pediatric communities, the gathering of epidemiologic data, the design of programs to support child mental health services, the definition of needs for the restoration of child health, and the exploration of the roles of children's doctors in the protection of children in difficult circumstances.

The Workshop

The city of Trieste sits in the extreme northeast corner of Italy, near the border of Slovenia, one of the five republics of the former Yugoslavia. A port city on the Gulf of Venice at the head of the Adriatic Sea, Trieste was part of the Austrian Empire from the fourteenth century until the end of World War I. The city was then claimed by Italy, but after World War II it was divided and, like Berlin, was administered jointly by the Allies. In 1954, after a plebiscite, its territory was divided between Yugoslavia and Italy, the latter assuming sovereignty over the city proper.

This history of a division that was overcome seemed a fitting backdrop to the workshop described here, which took place in Trieste from March 27 to 30, 1994. Thirty-four doctors who could speak for child health gathered at a hotel perched on a steep hill above the edge of the sea in response to a war not far away that was moving into what everyone hoped was its penultimate phase.

The workshop was convened by the National Research Council and the Institute of Medicine of the United States. The eight Americans and three Europeans who formed the organizing committee served as mediators, facilitators, and data gatherers for the meeting. They included leaders in academic pediatrics, officers of national and international pediatric associations, and veterans of humanitarian efforts.

The regional participants were chosen as doctors who could make a difference for children, including 19 doctors from the five countries that constituted the former Yugoslavia (five doctors from Bosnia-Herzegovina, two from Croatia, two from Macedonia, three from Slovenia, five from Serbia—including one from Kosovo and one from Novi Sad—and two from Knin and Banja Luka in Serbian-held areas of Croatia and Bosnia-Herzegovina, respectively.

The participants included doctors from trauma units and emergency wards who themselves had been targeted in the war; child psychiatrists who had witnessed sieges in which children have been made suicidal, some deliberately exposing themselves to sniper fire; the caretakers of refugees; doctors from maternity hospitals where infants routinely die from a lack of basic medicines, supplies, and equipment; doctors from frontline situations they had not left until they attended the workshop more than 1 or 2 years; and academicians and health leaders of their own countries and officials of pediatric societies and children's hospitals.

The organizing committee had formulated three central questions for the workshop: What is the state of child health in war-torn former Yugoslavia today? What can be done to improve it? And how might this knowledge be used to benefit other children in the world?

The discussions began with a series of presentations entitled "Children in My Vicinity." Each participant had been asked to prepare in advance a short statement describing particular conditions and problems of the children in his or her own region. These statements provided powerful and moving glimpses of child health problems as seen by the doctors who were responsible for the care of the children. In this report the key elements of these presentations, subsequent presentations, and discussions are summarized to provide an insight into the health conditions of children today in the countries of the former Yugoslavia. The ideas and statistics in the report reflect the material included in the presentations and discussions of the participants during the workshop. Specific references are provided for published materials.

EPIDEMIOLOGY: GETTING THE FACTS ON CHILD HEALTH IN DIFFICULT CIRCUMSTANCES

Accurate and standard management of data is necessary to understand health needs and to facilitate planning for the future in times of peace and war alike. Despite attention by the media and humanitarian organizations, little documented information has yet been available concerning the actual status of child health in the countries of the former Yugoslavia. It is clear that such data can be difficult to come by in wartime situations and that this difficulty is enhanced by rapidly changing circumstances. A number of challenges must be faced in addressing these issues, including the conditions under which the data are collected, the evaluation of the data, and the uses of the data. Furthermore, even when available, the data may be difficult to communicate and incorporate into decision-making processes. For these reasons, the workshop began with discussions of the challenges presented in obtaining health data in situations of war and difficult circumstances and on the needs for and the appropriate uses of such data. Indeed,

the workshop was developed on the premise that the availability of sound data is fundamental to addressing the health problems that result from conflict situations and that such data can also provide an important tool for the basis for reconstruction of society.

The first challenge is to select measures that adequately reflect the status of health under wartime conditions. One area to be examined is the trauma of war: killing, pain, injury, and disability. Another is the reappearance of previously controlled diseases such as tuberculosis that occur because of an inability to respond to them. Another is psychological trauma for the generation immediately affected, and perhaps for future generations as well. It is important to decide the impacts that should be measured so that suitable interventions can be prepared and applied.

The second challenge involves conflicting demands regarding potential uses of the data. Data are needed to prioritize programs, particularly when few resources are available, and data may be requested to track the outcomes of interventions. Scientific data can also be used or abused for advocacy or for political purposes when individuals or institutions seek to use scientific or medical data to justify specific actions or programs.

A third challenge in data collection has to do with the capacity to look beyond indicators and consider possible risk or developmental factors behind any measured occurrence. For example, in registering a case of diarrhea, one can also record whether the child was breastfed, when the child was weaned, the food-handling practices in the child's home, the child's hand-washing practices, and so forth. This approach to data collection starts an epidemiologic process in the mind of the data collector that will enhance knowledge about the conditions under which the problem occurred, thereby enabling the design of effective interventions.

Valid and practical indicators are essential to data measurement as is accurate assessment of basic facts. One example of a practical indicator is the use of imaginative techniques in conducting an epidemiologic study of the ways that children see things, especially children who have been traumatized. Children's pictures, essays, or poems may help to reveal which treatments have an impact in dealing with the experience of trauma. A similar technique is the "photo interview," in which children respond to a series of photographs. The skill and time of professionals are needed to interpret such tests, however, and these are not always available. The exact mix of measures differs in different situations, and the selection of measures must always be based on the skills of the measurers. The use of already validated measurement instruments saves the step of validation and provides a background based on more long-term experience. However, such instruments may not, unfortunately, be applicable to some situations. An example of the importance of accurate assessment of basic facts can be shown by considering the documentation of nutritional status. Valid

interpretation of malnutrition depends on the accurate statement of ages; rounding off of ages to the nearest year can lead to significant errors in judging the nutritional status of infants and young children.

Several techniques are available for measuring of health statistics under difficult circumstances. The first technique is to make use of already existing data. In some cases, however, such data may not reflect the current situation and may not be adequate for planning interventions. A second technique concerns what might be called *opportunistic monitoring*. One or two key questions about problems whose resolution is a high priority are asked at feeding supplementation or immunization programs attended by a large percentage of the population. A third common technique involves the use of surveys and rapid appraisals. It is important that such surveys be done in a way that can make them useful in decision making and other existing efforts and also to facilitate longitudinal follow-up. For example, in selected representative communities in an area, a household survey, an anthropologic survey, and a psychological survey of schoolchildren can be correlated in the same communities. Such surveys do not have to be elegant or complicated; indeed, they should be as simple as possible. More in-depth health surveys can also be developed, once a system of basic ongoing monitoring is in place. It is then possible to select a particular problem and look at every single case within a known area ("all cases everywhere technique").

The meaningful communication of data is very important. Data are relatively easy to acquire, but they are often difficult to communicate and incorporate into decision-making processes. Data need to be packaged and presented in a form that will allow them to have an impact. To say that infant mortality is 30 or 40 per 1,000 live births has relatively little impact; reformulating this statement to tell how many of 100 infants have actually died tells the story more effectively. It is important to place the concept of risk not only within medical and scientific contexts but also within contexts relevant to the community. One potential pitfall in the presentation of data that may be particularly applicable in conflict situations concerns the political and patriotic wish to present the best possible figures to support one's country. Such inflated reports of data may be helpful politically, but they are certainly not in the best interests of defining the problems that need to be addressed.

A final concept of epidemiology and measurement under difficult circumstances is what might be called *measurement for peace* (Andersson, 1993). This concept has recently emerged from the war in Liberia. In the process of collecting data in Liberia measurement teams of teachers and medical workers involved in the data collection process also addressed some of the health problems affecting children. Teams on various sides of the conflict measured simple things on a community level: the incidence of diarrhea and respiratory infections, the vaccination and nutritional status of children, and so forth. In so

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doing they caused large numbers of people to think about such problems, what lies behind them, and what might be done to remedy them. This process resulted in the people themselves, working through the measurement process, coming up with pertinent requests to various humanitarian aid agencies for intervention. In addition, many people, both the measurers and the measured, had participated in a humanitarian activity that focused attention on children and their problems. People from all sides of the conflict in Liberia, even those who had been guilty of perpetrating traumas against children, became involved in the process, a process that not only provided useful data for guiding the relief efforts of humanitarian aid organizations but also focused attention on children and steps toward positive change.

Summary

Describing the state of health, defining health needs, and planning for the future depend on the availability of accurate data in times of peace and war alike. Comparison of the state of health of children between regions or countries demands accurate gathering of data and standard management of those data. Discussions of epidemiology and data collection at the workshop focused on the difficulties of gathering data under circumstances such as war and the means by which such difficulties might be surmounted. The issues discussed included the conditions under which data are collected, the standard means of evaluating those data, and the uses of the data. Participants stressed that the availability of sound data is fundamental to addressing the health problems in conflict situations and that accurate and meaningful data can provide an important tool for beginning the reconstruction of society.

PRIMARY HEALTH CARE, PREVENTIVE MEDICINE, AND INFANT AND CHILD MORTALITY

After World War II, an admirable system of health care was established for mothers and infants throughout the former Yugoslavia. This system provided a model of comprehensive identification, monitoring, and the continuing follow-up of both mothers and children throughout much of the country. This model has now been disrupted in some areas by the war, leading to wide variations in the status of maternal and child health.

Discussions of infant and child mortality depend on clear definitions and common frames of reference. A number of questions were addressed by workshop participants in this regard: Is the viability of the fetus determined by gestational age or other factors? How does one define a live birth? Are

stillbirths counted in infant mortality statistics? Are the deaths of all infants or only those admitted to a hospital recorded?

Infant and child mortality is inseparable from prenatal and perinatal care and conditions. Maternal age, maternal nutrition, maternal stress, substance abuse (tobacco and alcohol), literacy, and the educational levels of pregnant women are all factors in infant outcome, as are the level of care that the mother receives during pregnancy and perinatally and postnatally.

Two European participants offered pertinent data in this regard. In the former West Germany infant mortality rates were rather high until 7 or 8 years ago, despite the relative affluence of the population. Implementation of two programs successfully lowered infant mortality in the former West Germany to levels comparable to those countries with low infant mortality rates. The first program involved regionalization of neonatal care, meaning that infants at risk were treated in large centers with intensive care units for infants. The second program involved implementation of a surveillance system for perinatal care, including risk assessment and a transport system for babies from the obstetric hospital to the pediatric hospital. Likewise, in Trieste, infant mortality rates were formerly 25 to 26 per 1,000 births; these rates fell to 13 per 1,000 births within 1 year of the institution of similar measures of perinatal care.

A Regional Review

During the workshop, reports of decreasing birth rates and rising infant mortality rates were reported from various regions, although in many cases hard data were lacking. These reports are highlighted below.

Bosnia-Herzegovina

Zenica. The previously well organized system of prenatal and postnatal care for mothers and children has been disrupted by the war. In Zenica there used to be three neonatologists, one intensive care physician, and one neurologist, in addition to pediatricians. Now only one neonatologist remains. Only 3 of 21 incubators are functional; there are often 3 babies in each incubator. Equipment is compromised by electrical failure and the lack of spare parts and maintenance. Perinatal mortality rates have doubled (given as from 14 to 16 per 1,000 before 1992, to 36 per 1,000 in 1993), as have rates of stillbirths (from 8 to 15 percent). Increased numbers of congenital malformations are suspected, with no clear pattern of types, and rates of premature births (birth weight of less than 2,500 grams) are also thought to be increasing. The occurrence of eclampsia in mothers has tripled over prewar levels, as have mental health problems during pregnancy.

Explanations for these trends include the lack of prenatal care, poor maternal nutrition, and increased stress. In Zenica there have also been major problems with refugee women who have been raped.

Mostar. The Gynecological and Maternity Hospital, Medical Center Mostar, is the regional hospital for Mostar and neighboring municipalities and served 500,000 people before the war. Before the war there were 4,000 deliveries annually. Two-thirds of the pediatricians have left Mostar, and none of the pediatricians now present is trained in neonatal medicine; half of the nurses have also left. The obstetric hospital has been on the front lines of the war; its bed capacity has been reduced from 100 to 20 functional beds, the rest being destroyed or converted into makeshift clinics. Facilities for prenatal surveillance have been lost, and laboratories are lacking in facilities for diagnosis and monitoring. It is also dangerous to go to the hospital: 3 pregnant women have been hit by shrapnel in the abdomen. Transport of high-risk patients is difficult because of communication disruption. Before the war high-risk mothers went to Zagreb, Croatia, but this is now difficult.

An important observation is that many pregnant women in the Mostar area gain excessive weight on a diet rich in starch, mainly eating foods available from humanitarian aid organizations. Increases in preeclampsia and abruptio placenta have been associated with this excessive weight. This paradoxical condition has been referred to as the *spaghetti syndrome*. The number of premature births has increased from 7.6 percent before the war to 9.7 percent currently, as has the rate of intrauterine growth retardation (from 6.4 to 11.6 percent). Anemia has been a common observation in pregnant women, affecting 84 percent of those with excessive weight gain and 46 percent of those with normal weight gain. The rate of breastfeeding has been declining.

Sarajevo. Data from Kosevo Hospital in Sarajevo also indicate a rise in infant mortality, from 16 per 1,000 prewar to 27 per 1,000 in 1993. The rate of stillbirths has risen from 7.5 to 12.3 per 1,000 over the same period, and there has also been an increase in the rate of premature births, from 6 to 12 percent. Fertility rates have fallen from 13.8 per 1,000 prewar to 2.2 per 1,000 in 1993, and abortion rates have risen from 29 percent of pregnancies prewar to 64 percent in 1993. Serious congenital malformations have risen from 3.7 to 7.3 per 1,000 (United Nations Children's Fund, 1993).

Primary Health Care. Bosnia-Herzegovina has experienced widespread problems with maintaining primary health care. Vaccination programs have been interrupted because of war and at times because of vaccine shortages. No epidemic of communicable diseases preventable by vaccinations has been reported, but there is concern that this may happen in the future. Immunization with the BCG vaccine against mycobacteria has been a problem in some parts of the country, and there is great concern about a resurgence of tuberculosis. Routine well-child visits and child health surveillance are now lacking. A few

nutritional surveys have not documented the occurrence of malnutrition or increased levels of anemia among children (World Health Organization, 1993), but sample sizes have been small and measurement techniques may not be exact. All participants from Bosnia-Herzegovina mentioned the problem of hungry children and reported widespread disruptions of basic sanitation, water supplies, and electricity. The general lack of supplies for proper hygiene such as soap, detergents, and disinfectants were thought to contribute to increased rates of diarrhea, hepatitis, scabies, and lice observed in Sarajevo, Zenica, and Tuzla.

Both displaced and local children have suffered from the lack of primary health care and preventive medicine. Displaced children are eligible to receive food from the United Nations High Commission for Refugees (UNHCR), at times ensuring that their nutritional needs are met more than those of nondisplaced children living in war zones.

Banja Luka. In Banja Luka, a Serbian-controlled city of Bosnia-Herzegovina, there have been many problems with maternal and infant care. Difficulties with transport have resulted in fewer prenatal visits, and functional equipment is often lacking (only one ultrasonograph is working). The number of births has been dropping (from 5,300 in 1988 to 3,341 in 1992), and fetal and infant mortality is thought to be rising. The rate of premature births was 9.8 percent in 1993. There are major problems in caring for premature infants; 50 percent of infants weighing less than 2,500 grams die, and no baby weighing less than 1 kilogram has survived recently. Causes of neonatal death include sepsis, respiratory disease, hypoxia, and intracranial hemorrhage. Problems with Rh factor incompatibility disease in newborns have risen because of the lack of the immunoglobulin used to prevent sensitization of mothers: parents must supply their own if they can. Phototherapy units and transfusion kits are in short supply. Deliveries of infants in the home are increasing, with the ensuing problems of hypothermia and neurologic damage to the newborns. A particularly severe problem has been the lack of oxygen and functional respiratory equipment; 12 newborns were reported to have died in hospital in 1992 and three in 1993 for the want of oxygen or incubators. As in Zenica, there are sometimes three premature infants per incubator. Hospitals experience sanitation problems because of the lack of basic hygienic materials for washing and sterilization of equipment, and infestations of insects and rats have been noted.

Croatia

Also greatly affected by the war, the republic of Croatia has maintained good levels of primary health care and maternal and child care despite the war. Although child health services remained in place during and after the war, increased risk factors for pregnant women were noted, including stress, poor diet,

harder working conditions, generally unfavorable conditions for childbirth, and inadequate care of mothers and newborns after delivery. These factors may result in increased rates of premature births and morbidity and mortality in infants and children, and the resulting defects and disabilities may lead to long-lasting effects that will remain after the war. The health and education infrastructure has been severely damaged, with 15 hospitals or medical centers destroyed and 14 others damaged, and 128 preschool centers, 335 primary schools, and 65 secondary schools damaged or destroyed. Eight homes for children and five children's rehabilitation centers have been destroyed or damaged. About 30 percent of the health care facilities have been destroyed by war, particularly in the regions of eastern Slavonia, and great burdens have resulted from the economic effects of war and the destruction of facilities.

Indications of decreased levels of prenatal care and increased rates of premature births and perinatal mortality are also being reported from Knin, representing a Serbian-held area of Croatia. Common factors include stressful living conditions for pregnant women, the lack of adequate prenatal care, and an inadequate capacity to care for newborns in the hospital because of shortages of medical supplies, oxygen, and disinfectants. Vaccine shortages have been reported, as well as shortages of powdered milk formulas for children in the first year of life. Adequate refrigeration of milk during the summer months is impossible because of frequent power shortages. Rickets has appeared in children, as has iron deficiency.

Macedonia

Although Macedonia has not been directly affected by war, its health services have been disrupted by a blockade of routes to neighboring Greece. In 1966 Macedonia had a high infant mortality rate (105 per 1,000) but child health services and preventive pediatrics efforts beginning in 1965 successfully reduced infant mortality rates to 28 per 1,000 in 1991. Infant mortality rates are thought to have increased to 32 per 1,000 in 1992 because of advanced maternal age and poor education, as well as perinatal causes, congenital anomalies, and gastrointestinal and respiratory infections. Immunization rates declined in 1992 and 1993 because of the lack of vaccines, secondary to the blockade; vaccine supplies are now dependent on air transport and humanitarian aid sources.

Serbia

Increases in infant mortality rates have been reported in Serbia (from 21.6 per 1,000 in 1991 to 22.3 per 1,000 in 1992) and in Montenegro (from 11.2 per

1,000 in 1991 to 13.2 per 1,000 in 1992). The Kosovo region has always had a higher infant mortality rate than the rest of Serbia (34.4 per 1,000 in 1992). Some cases of neonatal tetanus and poliomyelitis are also being reported. The health care system has been significantly affected by the economic impact of the war and the economic sanctions, with the resulting loss of general resources, medical supplies, medical equipment, and spare parts.

In Novi Sad, increases in premature births and birth defects are being reported, as are the complications of anemia, diabetes, and high blood pressure in mothers. A formerly good system of prenatal care, with five to six prenatal visits per mother and the wide use of ultrasound and monitoring devices, has deteriorated.

Slovenia

Primary health care, preventive medicine, and maternal and infant health are exemplary in this relatively small country, which has been at peace since 1991. All mothers receive prenatal care, all infants are born in a hospital, and all infants and mothers receive routine postnatal follow-up care. The infant mortality rate in Slovenia (8.3 per 1,000 in 1991) is one of the lowest in the world, and immunization rates exceed 90 percent.

Summary

A formerly good system of primary health care, preventive medicine, and maternal and child health has been disrupted by war in a number of republics, including Bosnia-Herzegovina, Serbia, and to a lesser extent, Croatia and Macedonia. Adverse changes include decreased levels of prenatal care, decreased capacity for monitoring pregnancies, disrupted transport systems for high-risk pregnancies, increasing rates of premature births, decreased capacity to care for premature infants, increasing rates of infant mortality, decreasing immunization rates, widespread incapacity for basic hygiene and sanitation measures, and suggestions of an increase in congenital malformations. The available data are not standardized, however, and are sometimes confusing. The workshop participants generally agreed that the development of standard measurements and the collection of standard data concerning maternal and infant health in all of these countries would be useful for future planning.

Prior to its divisions, Yugoslavia had a centralized, state-run health care system that provided widespread access to health care and maternal and child health services. A number of countries, including Serbia, Macedonia, and Slovenia, are now considering measures to privatize the health care systems. This

has raised concerns about the ultimate effects of such changes on the access of mothers and children to primary and preventive health care and of children to curative health care.

Control of the health care system for children is another area of concern. In some countries, such as Slovenia, primary care physicians or family physicians, rather than the pediatricians who have traditionally managed child health services, would direct child health. In some countries, such as Serbia, some aspects of child health such as primary health care and prevention would be transferred to family physicians, and pediatricians would be retained for other duties. Many participants expressed concerns about these changing systems, their economic and social effects on accessibility to medications and services, and the treatment of those who cannot afford to pay for medical care.

In addition to these changes in the health care system, tremendous burdens are being imposed on countries such as Bosnia-Herzegovina and Croatia, whose health care and educational facilities have been destroyed and which have lost health care personnel, supplies, and equipment.

TRAUMA

Even without wars, trauma and injury are major causes of childhood mortality and morbidity and are major reasons for hospitalization and the utilization of health care resources by children in the United States and throughout the world (Institute of Medicine, 1993). Through collaborative efforts, pediatricians and surgeons have sought to improve the means of preventing childhood injuries as well as treating them. Many leading causes of childhood injuries such as falls, motor vehicle accidents, and house fires can be controlled or prevented. Rapid and efficient transport is often missing not only in places of armed conflict but also in many parts of the United States, both urban and rural.

Because children's physiologic reserves are less than those of adults, children demand more rapid transport and initial resuscitation. The treatment of multiple trauma and multiple systems injury requires basic principles of care that are well known: achieving an airway, respiration, and circulation. Many emergency physicians are not aware of the special problems of children, such as the anatomical differences of infants that affect the skills required to achieve an open airway. Breathing and ventilation are different in infants and young children; for example, their chest walls are so mobile that a small pneumothorax may cause significant changes, in both circulation and ventilation. The earliest sign of inadequate circulation in the adult is usually a drop in blood pressure, but the earliest sign in a child is an increase in pulse; children's blood pressures do not drop until they have lost 35 to 40 percent of their blood volume. These kinds

of special needs of children require consideration in training programs and emergency rooms.

The basic principles are the same in the management of trauma as in the management of life-threatening illness in children. The initial treatment for a child with an overwhelming infection is similar to that for one with the hypovolemia of shock. Techniques such as intraosseous infusion can be lifesaving in a child who has received trauma. Injuries to spleens and other organs from blunt trauma can often be managed with careful monitoring but without operative intervention, because the young tissues of a child often will stop bleeding.

Unfortunately, the worldwide problem of trauma and injury for children has been greatly magnified by war in Bosnia-Herzegovina and Croatia. The workshop participants reviewed the available data and experience with trauma and injury in the countries of the former Yugoslavia to gain some insight into the special features of child trauma in these regions.

Bosnia-Herzegovina

The most devastating effects of trauma on both children and adults have been felt in Bosnia-Herzegovina. Because of the disruption of this country by war, there has been great difficulty in compiling statistics. From April 1992 to March 21, 1994, 61 of 101 communes in Bosnia-Herzegovina reported casualties (Table 1).

The almost equal numbers of killed and wounded overall reflect both the severity of the injuries and the lack of access to care for trauma in many areas; the ratios of killed to wounded in Sarajevo are 1 to 6 for adults and 1 to 9 for children. At Kosevo Hospital in Sarajevo, the largest trauma service in Bosnia-Herzegovina, 70 to 80 percent of the wounded have been civilians.

Causes of Injuries

In Sarajevo mortar shells (both 60- and 120-millimeter shells) have been the most frequent cause of injuries. Such shells contain many pieces of shrapnel that act as secondary missiles. During the shelling of Sarajevo mortars have sometimes fallen at a rate of 120 per minute for hours on end. When such mortars fall on asphalt or hit buildings at great speeds they explode and generate fragments of pavement and building materials that cause injuries both to the lower extremities and to the head and upper parts of the body. Such injuries can resemble those caused by land mines.

TABLE 1. Numbers of People and Children Killed, Wounded, or Seriously Disabled in Bosnia-Herzegovina and Sarajevo, April 1992 to March 1994.

Casualty and Group	Bosnia-Herzegovina	Sarajevo
Killed or missing		
Total Population	142,629	9,951
Children Only	16,548	1,564
Registered as wounded		
Total Population	162,512	58,183
Children Only	33,829	14,816
Seriously disabled		
Total Population	9,200	1,680
Children Only	1,820	340

SOURCE: Bosnia-Herzegovnia Institute of Public Health, 1994, and United Nations Children's Fund Estimates.

The second most frequent cause of war injuries in Sarajevo has been snipers who have targeted individuals of all ages, including women and children. The Sarajevo surgeons have noted seemingly deliberate patterns of injuries. On some days chest or abdominal wounds predominate, on some days it is wounds of the lower body, on some days it is head wounds, and on some days it is children.

Patient Volumes and Associated Problems

The volumes of trauma patients at Kosevo Hospital have been staggering. On the worst day, June 8, 1992, 328 wounded people were brought to the Trauma Unit at Kosevo Hospital. Most patients arrive in cars or trucks because most of the ambulances have been destroyed. About 100 trauma beds are available, but trauma patients often overflow to other services. The heavy loads of trauma patients disrupted schedules for other surgeries. For example, patients with carcinoma may receive no surgery (and also no chemotherapy).

The problems of caring for large numbers of trauma patients have been compounded by the fact that Kosevo Hospital has been heavily bombarded. The operating rooms and the sterilization block appear to have been targeted. Because of this surgery has often been conducted in three small operating rooms in the basement rather than in the regular operating rooms on the first floor. One surgeon has been killed in the operating room. There are no shelters in the hospital, and there has been no safe place to hide. A major problem has been where to put the patients to convalesce. The medical staff made a decision early

on to leave patients in their rooms during the shelling rather than to concentrate them all in one place, where a direct hit would be disastrous. Ambulances and ambulance crews have also suffered. Of 20 to 30 ambulances, only about 4 are left; the ambulances appear to have been targeted. Nine or ten doctors and a few nurses, some in ambulances, have been killed by snipers. At the time of the workshop, the staff on the trauma service consisted of nine general surgeons, two pediatric and three thoracic surgeons, six residents, and about 75 nurses.

Supply and Personnel Shortages

Since May 1992 the Kosevo Hospital has operated most of the time without communications, a regular water supply, or electricity. Operations have been conducted by daylight or with solar headlamps, flashlights, or candles, saving generator fuel for real emergencies. After rupture of the water supply in May 1992, water was supplied from a 6,000-liter water tank that, when possible, was filled on a daily basis with springwater from a beer factory. The hospital laundry has been run with a small washing machine and with the help of families and citizens who take away sheets and pajamas to be washed outside of the hospital.

Materials shortages are also severe. For example, 70 percent of the patients have had injuries to their extremities but there have been insufficient external fixation devices. The staff has improvised and produced new types of fixation apparatuses. Sterilization of instruments has been a problem, exacerbating a lack of instrument sets. At times instruments have been sterilized by a "museum piece" autoclave fueled by a wood fire. General supplies are extremely short, including items such as scrub suits, operating room clothes, and so forth.

Despite the lack of personnel and the heavy workload, the trauma surgeons in Sarajevo have sent teams out to the field, realizing that as difficult as things are for them, they are still better supplied than their colleagues in other areas.

Surgeons trained in techniques such as microsurgery and the repair of nerve injuries are lacking. Additional surgical personnel would allow some respite for the local surgeons and would also address the backlog in general surgery. The hospital has been totally dependent on humanitarian aid for food and supplies. Food has often been inadequate, and both patients and staff have been hungry. Indeed, the workshop participants were struck by the extreme thinness of the doctors from Bosnia-Herzegovina, one of whom had lost 40 kilograms of body weight since the beginning of the war.

Croatia

The new building of the Children's Hospital in Zagreb, Croatia, completed in 1989, included a bomb shelter because of regulations imposed by the Federal Yugoslav Army. This shelter was built to accommodate 400 people and has accommodated staff and children from the 300 beds of the hospital on several occasions since the war in Croatia started in 1991.

Numbers and Ages of Victims

A registry of child victims of the war in Croatia was established in the Institute for Maternal and Child Health in Zagreb in the summer of 1991. This registry has been updated continuously. Data have been collected from reports from health institutions, Medical Corps Headquarters, the Ministry of Health, the Ministry of Labor, the Ministry of Social Welfare for Families, the Office for Victims of the War, and the Office for Displaced Persons and Refugees in the Republic of Croatia (Institute for Mother and Child Health, 1994).

From the beginning of the war in July 1991 until December 1993, 236 children were registered as killed and 802 were registered as wounded. All of these cases have been registered and documented; there may actually be about 30 percent more in both categories. Children represent about 10 percent of those killed and wounded in Croatia.

The highest number of Croatian children were killed or wounded during the most intense period of the war in the summer and autumn of 1991. Before the final ceasefire agreement of January 3, 1992, 115 children had died and 495 had been wounded. As the war has continued, another 121 have been killed and another 307 have been wounded. Children of all age groups, from infants to youths, have suffered. The youngest victim of the war was a 4-month-old boy; the oldest a girl of 17 (Table 2).

Most casualties are in those ages 11 to 14 and 15 to 17 years, making up more than half of the casualties. Boys have been injured more frequently than girls, as is the case with accidents in peacetime. Seventy-two percent of the children killed and 75 percent of the children wounded are boys. The most imperiled group are boys ages 11 to 14 years who are affected three times more frequently than girls of the same age.

Although the majority of casualties have been registered in areas of actual conflict, children have also suffered in areas far away from the battle lines. This is the consequence of long-range artillery and air bombardments. The majority of children who have died and who have been wounded have come from eastern Slavonia (48 percent) and H. Primorje and Dalmatia (23 percent).

TABLE 2. Killed and Wounded Children in War in Croatia, to March 25, 1994, by Age.

	Children Killed		Children Wounded	
Age (years)	Number	Percent	Number	Percent
0–6	45	19	127	16
7–10	39	17	142	18
11–14	55	23	224	28
15–17	76	32	280	35
Unknown	21	9	29	3
Total	236	100	802	100

SOURCE: Institute for Mother and Child Health, Zagreb, Croatia, March 25, 1994.

Cause of Injuries

The main cause of injuries in children has been the direct targeting by weapons of war, accounting for about 90 percent of the dead and about 80 percent of the wounded. For each case detailed information has been kept on the cause and type of injury.

In the majority of cases, children have been injured in artillery attacks and bombings of their homes or as they were fleeing the war. The injuries are those commonly inflicted by heavy and light artillery weapons, shrapnel bombs, and rocket fire. Extensively and deeply torn tissues with multiple injuries are the typical consequences of explosive devices. Bullet wounds are less common among children, since children are not usually on the front lines.

Besides a large number of children who have been killed and wounded, many children have been permanently disabled. Of 75 children currently known to have permanent disabilities (an incomplete figure because data are not yet available) 13 have lost extremities and 10 have brain damage.

The transport of wounded children and adults to surgical centers such as Zagreb was an enormous problem recognized early in the war. Despite the relatively short distances, such transport might require 2 to 3 days. Consequently, individuals were dying near the front lines, and the mortality rates for trauma patients in the Children's Hospital in Zagreb were zero since the most severely injured patients had died. The Children's Hospital subsequently developed teams

of pediatric surgeons who went out to the front lines, especially to eastern Slavonia, and provided frontline care. There have been shortages of expensive equipment, notably external fixation devices for limb injuries.

The wide distribution of unexploded mines and other ammunition is a major child health hazard in Croatia, and one which will remain for years to come. Unexploded mines, bombs, grenades, and mortars cover the land, particularly in eastern Slavonia. These weapons are stumbled on by children, who sometimes play with them, leading to potentially disastrous results. Furthermore, many small arms are available, which are again a source of trauma for children. There have been a number of incidents of children inflicting injury or death on themselves or others with such weapons.

Land mines and unexploded weapons are also known to be a problem in Bosnia-Herzegovina, although no statistics are available. Many Bosnian children have not emerged from shelters for extended periods of time, so the full extent of this hazard is not yet known. Mines are known to exist around all of the Bosnian areas represented at the workshop, including Sarajevo, Tuzla, and Zenica, and also in the areas around Knin and Banja Luka. In Knin six children were reported to have been killed by shells or mines, and 40 have been wounded.

Serbia, Macedonia, and Slovenia

Trauma and direct injury of children from war have not generally been reported in Serbia, Macedonia, or Slovenia. Children in these areas suffer the same kinds of childhood trauma as children in other countries. Refugee children from rural Bosnia-Herzegovina who are now living in Slovenia have become subject to motor vehicle accidents; many of these children are not familiar with major highways and rapid auto traffic.

Convalescence and Evacuation

The workshop participants explored the complexities of the problem of where to send children for convalescence when they are well enough to leave the hospital. Often, injured children have neither a home nor a parent who can care for them. Furthermore, the residences that do exist may lack the basic resources for survival such as food and warmth.

A second issue involves the circumstances under which children should be evacuated for care to other countries. In certain instances, such evacuation can be helpful—for example if the capability to care for children does not exist in the home situation. However, many problems can arise if children are separated from their families or if the care that is instituted abroad cannot be sustained in

the host country or at home. Most discussants favored strengthening local capacities to care for children in their own countries over performing large-scale evacuations and stressed the importance of having family members accompany any children who are evacuated.

Summary

Trauma is a major health problem for children, a leading cause of mortality, morbidity, and utilization of health resources for children in countries worldwide. The management of trauma in children differs in important ways from that in adults; children are unique not only in their lack of full growth and development but also in their physiology. Appropriate management of childhood trauma demands both pediatricians and surgeons knowledgeable in the principles of pediatric medicine and trauma and trauma services that are geared to the care of children. In general, childhood trauma has been a neglected field throughout the world.

In the countries of the former Yugoslavia, especially Bosnia-Herzegovina and Croatia, war-related childhood trauma has been a major cause of childhood mortality and morbidity since the wars began in 1991 and 1992. The major causes of trauma have been gunshots, shelling, and land mines. The ratio of children who have died to those who have been injured has been high, reflecting both the severities of the injuries and the severe difficulties with transport and evacuation. Land mines will present a continuing problem in many parts of these countries for years to come, as will the availability of weapons and unexploded munitions. The number of children who have been permanently disabled has yet to be defined; these children will require continuing care and rehabilitation. The principles of keeping children with their families and close to their home communities when possible were stressed by all participants.

Because of the load of trauma and trauma surgery in Bosnia-Herzegovina and Croatia, children with routine pediatric surgical conditions such as cleft lip and palate have not received timely surgery, and they have also suffered secondarily because of war-related trauma.

ACUTE AND CHRONIC ILLNESSES

The incidence and prevalence of acute and chronic illnesses in children in the countries of the former Yugoslavia are not well documented, but the workshop participants offered several comments and presentations that highlight important issues.

Acute Illness

No major outbreaks of diseases preventable by standard immunizations have occurred, but the apparently declining and sporadic capacity for immunization in some countries, notably Bosnia-Herzegovina and to a lesser extent Serbia and Macedonia, is a continuing source of concern. Outbreaks of measles have been reported from the Kosovo area of Serbia. Acute respiratory diseases—upper respiratory infections, croup, bronchiolitis, otitis media, and pneumonia—were mentioned as a problem by several workshop participants, but they were not discussed in detail.

The most common acute problem mentioned was gastroenteritis. Given the breakdown of safe water supplies and sanitation in war zones, this has been a major problem in many areas of Bosnia-Herzegovina, particularly among populations of displaced people. Gastroenteritis has been a frequent health problem for years in both Macedonia and Kosovo. In Kosovo an epidemic of salmonellosis occurred recently; 82 cases occurred following contamination of the water supply in a home for mentally disabled patients. Salmonella infections have also been described as a nosocomial problem in hospitals in Serbia, particularly in newborn, psychiatric, and rehabilitation departments. Contact or oral modes of transmission are suspected. Neither cholera nor typhus has been reported. Clusters of hepatitis A virus infection have occurred in Zenica, Sarajevo, Bosnia-Herzegovina, and in Kosovo. Infestations of both children and adults with lice and scabies are common in war zones, particularly in Bosnia-Herzegovina, and they particularly affect displaced populations.

A number of cases of human immunodeficiency virus (HIV) infection have been reported in Sarajevo, as have several clinical cases of AIDS. Given the history of rape in these wars and an apparently growing problem with prostitution in adolescents as well as adults, HIV and other sexually transmitted diseases are of great concern.

Chronic Illnesses

The workshop participants expressed a general fear that the incidence of tuberculosis will increase, although no statistics are available to document this at present. In the former Yugoslavia, BCG vaccine was routinely given at birth and in several subsequent doses until the adult years, the latter being preceded by purified protein derivative (PPD) testing. BCG vaccine has been unavailable at times in some locations, although the overall supply is now said to be adequate. However, United Nations agencies do not supply PPD, and this has resulted in a lower level of BCG revaccination in some populations. Furthermore, with more children being born outside of hospitals, not all newborns are

receiving BCG vaccine. The lack of PPD, radiographic film, and laboratory facilities to examine sputum for tubercle bacilli all contribute to the lack of a capacity to detect tuberculosis. The unpredictable and often limited availability of drugs for the treatment of tuberculosis is also of concern.

Discussions of asthma, one of the most common chronic childhood conditions, gave rise to some paradoxical observations. In some areas the collapse of industry has resulted in less air pollution, implying the removal of an environmental stimulus for reactive airway disease. On the other hand, asthma remains a major health problem in a number of areas, and it is speculated that the stresses of war and living conditions trigger attacks. Shortages of the drugs used to treat asthma were reported for a number of areas and were considered to be a major problem.

Treatment of children with diabetes mellitus has at times been difficult because of the lack of insulin. The availability of insulin differs across the regions. Reports of children who died of diabetic ketoacidosis because of the unavailability of insulin came from Zenica in Bosnia-Herzegovina and Serbian-controlled regions near Knin in Croatia. Shortages of insulin and other drugs may be related as much to problems of distribution as to supply problems. An apparent increase in the incidence of diabetes mellitus in children in some areas raised the question of the influence of psychological stress on susceptible hosts.

Seizure disorders have presented a problem for children because of a lack of anti-seizure medications in locations such as Bosnia-Herzegovina and Macedonia.

Treatment of children with leukemia and other forms of malignancy and congenital heart disease has been particularly difficult because of the lack of specialists, transport difficulties, and the lack of drugs and treatment capacity. Anticancer drugs have generally not been available in war zones, and the evacuation of children has been difficult. The capacity to evaluate and manage congenital heart disease has also been lacking. Children with defects such as cleft lip and palate and congenital hip subluxation are not receiving appropriate management and may suffer the permanent effects of not learning to speak properly in the case of the former and permanent hip damage in the case of the latter. The care of children with developmental disabilities and birth defects has also been greatly compromised. Rheumatic fever and rheumatic heart disease have been reported in a number of areas, but it is not clear that cases are increasing. Children with hemophilia can no longer receive antihemophilia factor in several areas. These discussions made it quite clear that children wounded or killed by the war were not the only casualties in these conflicts.

An increased frequency of nosocomial infections was reported in many hospitals in Serbia by physicians and other health professionals. Infections have been noted in patients of all ages and on all services. The disease is thought to be spread most often by direct contact; this is followed by the airborne and oral

modes. The organisms reported to have caused nosocomial infections included salmonella, adenovirus, and staphylococcus. The occurrence of salmonella in particular was attributed to a lack of supplies and capacity for basic hygiene.

In a different region, in Banja Luka in Bosnia-Herzegovina, problems with contaminated milk were traced to a lack of gloves, soap, and hot water. The United Nations Children's Fund (UNICEF) physician representative reaffirmed the observation of nosocomial infections and indicated that they could be prevented by proper hygienic measures and the availability of appropriate supplies.

Some areas have experienced difficulties with antibiotic supplies such as benzathine penicillin for the prophylaxis of rheumatic fever. Shortages of iodized salt are associated with a rise in goiters, although iodine-deficient goiter disease has been a long-term problem in the Balkan regions, affecting as many as 12 percent of schoolchildren in Slovenia. Several participants from Macedonia, Bosnia-Herzegovina, Kosovo, and Knin mentioned an apparently increasing incidence of rickets in children. They were not certain of the causes, but a lack of oral vitamin D was suspected. In Macedonia rickets has been associated with the problem of seizures at the beginning of spring, when children go outdoors into a sunny environment. There was a general consensus that many children were poorly nourished, perhaps increasing their susceptibilities to common infectious diseases.

Summary

Although there have been no major epidemics of communicable diseases, there have been problems with both acute and chronic illnesses in children in the countries of the former Yugoslavia. The most problematic acute illnesses are respiratory infections, gastroenteritis, scabies, and lice. There is concern about sexually transmitted diseases, notably AIDS. For children with chronic conditions such as asthma, diabetes, malignancies, seizure disorders, congenital heart disease, birth defects, and chronic disabilities, care has been difficult and inadequate in many areas. In the war zones of Bosnia-Herzegovina and Croatia, children with chronic conditions have often not received the needed surgery or medical therapy because of the heavy load of children wounded by the war. This delay in therapy may result in death or permanent disability. The treatment of chronic conditions requiring drug therapy has often been hampered by a lack of suitable drugs. Nosocomial infections may be on the rise because of the lack of basic hygiene and proper supplies, and there is concern about an increase in tuberculosis compounded by difficulties in the diagnosis and therapy of

tuberculosis. Deficiency conditions such as goiter and rickets are occurring regularly in some areas.

Many acute and chronic illnesses could be prevented by relatively simple measures such as basic hygiene and sanitation; the use of dietary supplements such as iodine, vitamin D, and iron; and the appropriate distribution of needed medications. More challenging problems include the management of complex chronic conditions such as malignancies and heart disease, the delivery of specialized care under difficult circumstances, and the transport of children to centers with the capacity to provide appropriate care.

MENTAL HEALTH

Throughout the workshop participants from many different specialty areas and from various geographic regions of the former Yugoslavia suggested that mental health and psychosocial problems were among the paramount problems facing children throughout this region. Participants suggested that the majority of children and adolescents have been affected psychologically by war, whether or not they have been exposed to direct conflict situations.

A number of surveys in the past 2 years have demonstrated high levels of psychological symptoms in both refugees and children in war zones. Additional data show similar problems in children living in areas not directly exposed to war. The evidence of psychological trauma seems established, although studies are not based on common instruments and perhaps are not directly comparable. The plight of mentally retarded and institutionalized children is tragic in many parts of the former Yugoslavia. In parts of Bosnia-Herzegovina some such children have died. In all of the countries their continued care has become more difficult.

Workshop participants included senior representatives in the area of child psychiatry in the former republics who presented their own approaches to addressing the massive mental health problems at hand.

Bosnia-Herzegovina

Among a random sample of children in Sarajevo, it was shown that more than 60 percent of children have suffered psychological trauma (United Nations Children's Fund, 1994). It is expected that the full impact will be worse after the war. The children of Sarajevo and some other parts of Bosnia-Herzegovina have been subject to almost 2 years of constant bombardment and severe trauma, many witnessing firsthand casualties and injuries to members of their own

families. Children have faced a daily barrage of gunfire and artillery and have been confined to their homes for long periods for safety and shelter.

Dr. Ninaslava Vucak gave a moving description of the plight of children in Zenica:

> Our children live in cold flats and homes with their fathers gone to war. Mothers are alone, they themselves have a lack of love, and they have no time to devote attention to children. Children do not smile now. For six to eight months the kindergartens have been closed. Schools are held one day but not the next. There is a shortage of teachers and of school buildings. We are struggling for a living. People are famished. A famished, sad mother cannot provide for children. Rooms are dark and partitioned on all sides. There is little protection from grenades. No birds are singing, no rooms are sunny, no windows are open. We hear only guns. We are deeply concerned about the future of all the children of war. Children play games of war now. Mars is their only god. We need to tell our mothers, "Give your child a little love. Play with your child."

Rape in these wars has affected not only women but also adolescents and children. For example, one participant described two young girls of about 9 years of age who had been raped in one neighborhood and then sent across the bridge into Sarajevo. Many rape victims have experienced acute psychoactive states and depression. Some wish to hide the fact that they have been raped and never seek assistance. The consequences of rape, including HIV infection and AIDS, were discussed. Prostitution is also a problem that appears to be increasing not only in adults but also among girls as young as 11 or 12 years of age. Drug abuse is emerging as a problem, with marijuana, cocaine, and heroin in evidence; alcohol abuse seems less of a problem, perhaps because alcohol is quite expensive.

Before the war, suicide was a rare occurrence in Sarajevo, but now there are reports of suicides among both adults and children. Some children appear to have deliberately exposed themselves to sniper fire. One 12-year-old girl recently wrote a letter to her friends in which she divides up her possessions before she took her own life.

Posttraumatic stress disorder and other mental health symptom complexes became obvious 6 to 12 months into the war. In October 1992, a seminar on psychiatry and the war was organized in Sarajevo. Since then, the effects of sustained trauma on children and civilians have become increasingly apparent. Mental health facilities such as the psychiatric clinic in Sarajevo have been damaged, and psychiatry staffs have disintegrated.

Brief group psychotherapy has been the only treatment available to traumatized children, most of whom continue to live in stressful environments. In one 6-month program, mental health professionals visited children in their homes because of the dangerous conditions children encountered when they went to the clinics. Psychologists, general practitioners, and others, involving

colleagues in Trieste, Paris, the World Health Organization (WHO), and the United Nations' Children's Fund (UNICEF), are considering joint cooperative agreements to coordinate efforts to deal with trauma, healing, mental illness, family problems, posttraumatic stress disorder, and respite care for caretakers. Workshop participants explored the need for a regional mental health center, to be located in a neutral site such as Trieste.

The psychiatry clinic in Sarajevo has a small residential program for high-risk patients, including elderly individuals and those with chronic mental disorders. This clinic includes two child psychiatrists and one psychologist, but it has a limited capacity to implement treatment plans. A few professionals come from Holland and France on a monthly basis to help, but this has been insufficient. Many local physicians and psychiatrists themselves have depressive symptoms, creating a need to broaden the scope of professional effort focused on mental health.

Croatia

The experiences of mental health professionals and pediatricians in Croatia suggest that nearly all of the 900,000 children in this region have been affected by the war, through either direct experiences with dislocation or the experiences of living in a country under severe strain. Children play war games, use pretend or real armaments as toys, and draw pictures of war. New therapeutic models have been developed in response to the large numbers of children and families who require assistance. The Institute for Mother and Child Health in Zagreb has issued a booklet on the early identification of stress, as well as the minimal nutritional and health care requirements for children. A commission to coordinate assistance for child victims of war has been established in Croatia and includes representatives from child health professions in Croatia and also representatives of UNICEF, WHO, and various nongovernmental organizations. This commission has dealt with issues such as nutrition, primary health care, vaccination, and drug therapy and has also helped in the development of programs providing psychosocial assistance. Two regional centers have been established in Zagreb and Osijek, and two more in Rijeka and Split are proposed.

The Croatians have proposed a pyramidal model that rests on a base of providing practical help to all children, including health assessment and care, material assistance, health supplies, education, and rehabilitation. Mental health care is provided on three levels. The basic level fosters training and engaging community-based professionals who are in regular contact with children and their families—such as teachers, social workers, nurses, and volunteers—in techniques of emotional and social intervention. The role of these professionals is to facilitate the availability of concrete services such as child care, education, and

employment opportunities within a family through their contacts with the families in residences, kindergartens, and schools. The second level involves social workers, nurses, family doctors, teachers, special education teachers, and individuals from humanitarian organizations such as UNICEF and WHO who are trained and mobilized for task-oriented group interventions. The scarcity of professionals to treat the children in Croatia who might benefit from such treatment inhibits the use of group therapy, however. The third and most specialized level involves clinics and professionals in child psychiatry who can intervene with psychotherapy and other measures. This type of intervention is practical for only a minority of children. Many workshop participants emphasized that sophisticated forms of mental health services are not realistic in situations that involve large numbers of traumatized individuals.

Mental health programs in these areas require the use and development of good indicators for evaluation. This area represents one important opportunity for future links with academic mental health programs in other countries.

Although much of the workshop discussion focused on the mental health problems of children and war, reference was also made to children with problems such as hyperactivity, autism, developmental disorders, early-onset psychosis, and so forth. Croatian children and adolescents, especially nonrefugees, seem to have experienced increased psychosocial problems, although it is difficult to separate the overall effect of the war on the mental health of all citizens.

Serbia

Child psychiatry services have been well organized in Belgrade and throughout Serbia. In 1991 an influx of refugees came into Serbia, many from Croatia and Bosnia. Many of these refugees have stayed near the borders, hoping to return home, or have settled in large towns because of the illusion of greater safety. Informal studies of refugee children by use of semistructured questionnaires have indicated high levels of mental health problems that appear to be more severe in children living in collective centers than those living in homes. Mental health services for refugee children have involved primary health care services; school psychologists, and the Red Cross, and other humanitarian organizations have also been involved.

The Institute of Mental Health in Belgrade has established training seminars for school psychologists, teachers, and primary health care workers and has prepared a curriculum booklet. In 1992 and 1993 these manuals for refugee mental health and the psychosocial consequences of war were translated and have now been published in a book *Stresses of War* (Kalicanin et al., 1993).

In 1993, 100 primary health care workers and pediatricians were trained to assess and address mental health problems. This curriculum lasted 3 months, with

2 consecutive days of training per month and periodic visits from Institute staff to the centers where pediatricians had been trained. Pediatricians and psychologists from areas with the highest densities of refugees were chosen. In evaluating the effectiveness of such programs, pediatricians were asked to register the psychological symptoms among children who had come to them for somatic illnesses, and a prevalence of the mental disorders detected in children consulting pediatricians was thus established. This approach found that 9 percent of local children, and 30 percent of refugee children, were affected by mental disorders according to the scales used. These findings are very close to the prevalence of disorders detected by mental health professionals, and they suggest that there was no significant difference in the assessments between trained pediatricians and mental health professionals. Furthermore, pediatricians are able to give basic interventions such as family counseling along with the other kinds of treatment needed by children and their families.

An increase in violent and aggressive behavior has been noticed in the local populations of children and adolescents in Serbia. It is of concern that adolescents are somewhat of a lost group in the eyes of humanitarian organizations; for example, UNICEF programs provide services for those aged 14 years and younger. Other problematic issues include drug abuse, early engagement in sexual activities, and antisocial behavior. A program of youth clubs established through the Institute was developed in Belgrade and is expanding to other areas. Experience with programs for violent youth in the United States and other parts of the world could provide helpful inputs.

A group of 102 refugee children and youth between the ages of 8 and 18 years were studied in Novi Sad. Nearly all were found to have problems, including sadness, anxiety, and easy distraction, differing significantly from the numbers of a control group of local children with such problems. Psychosomatic symptoms were noticed in children 16 years and older, but not in younger children. These refugee children did not identify themselves as people who were taking part in the war, and 84 percent of them assigned a negative meaning to the word *refugee*. War to them represented stress, family divisions, death of parents or family members, destroyed homes, departure from normal living, and adjusting to a new lifestyle.

The Serbian participants in the workshop emphasized the need for scientific information in psychiatry, recommunication with the world medical community, and respite care for the helpers, not only for those working in Belgrade but also for those working in other parts of the country.

Slovenia

In Slovenia mental health problems similar to those described in the other former Yugoslav republics have been noticed. Although Slovenia was involved in direct warfare only for a brief period of time in 1991, a rise in violent and antisocial behavior in young people and adolescents and increasing problems with drug use have been documented. These problems seem similar to those described by individuals from the other countries.

Slovenia received considerable numbers of refugees, as many as 80,000 to 100,000, mostly from Bosnia-Herzegovina. At present an estimated 30,000 refugees live in Slovenia, with 21,000 of them living with families and 9,000 living in refugee centers. As in other areas, most of the refugee children have suffered mental health consequences. Intervention programs in Slovenia have involved local professionals who have access to children, most notably schoolteachers. Discussants at the workshop noted that psychiatrists have traditionally waited for children to come to them, but that in situations like this, psychiatrists need to enhance the training of those professionals who encounter most children on a regular basis. The involvement of institutions with routine access to children, such as schools and kindergartens, is often important to the success of intervention programs. Innovative efforts have been developed to train teachers in techniques of recognizing and helping disturbed children, and school-based programs appear to be more effective than family-centered interventions.

The Slovenian mental health system for children has been severely challenged by the thousands of refugee children who require assistance. Few refugee children went to the clinics for consultation. Mobile teams from mental health clinics visited refugee camps, with a team consisting of psychologists, psychiatrists, and special teachers. As a first step in offering effective assistance, they acknowledged the stressful circumstances in which the refugee families were living. Many teachers in the schools are refugees themselves and they have received special training, psychological help, and consistent support at follow-up visits.

Programs of interest in Slovenia included Volunteers Helping Refugee Children, Kindergartens for Refugee Children, and Professional and Vocational Orientation for Eighth-Grade Children. Teenage children in particular are suffering and lack a clear sense of their future careers or vocations. The Slovenians have established mobile mental health teams, visiting centers, and therapeutic interventions for children with more severe problems and are also concerned about the general need for mental health support for caregivers.

The matter of simple human kindness in dealing with childhood trauma was emphasized. On a human level, children can learn firsthand that the world is not an entirely bad and unsafe place and that there are caring individuals who wish to do good for rather than evil to children. Such human input may be more practical and important than what is considered traditional psychiatry.

Summary

Mental health professionals in the countries of the former Yugoslavia have been quite innovative in their approach to a massive problem. New scientific information is being generated about the impact of traumatic stress on children and young people, and new ways of coping with large-scale disasters and prolonged emotional trauma are being instituted. These efforts may prove to be important in a much wider sphere than the countries of the former Yugoslavia. The evidence at hand suggests that the kind and extent of psychological disturbance depends on a range of factors, including personal vulnerability, family support and stability, and social setting. Psychological effects seem related to the type, the degree, and the duration of exposure to traumatic events, as well as to the number of stressors. Such effects may appear among refugees, the homeless, and those exposed directly to war, as well as individuals, including children, living in traumatized families, under poor economic conditions, and indeed, in a traumatized society where normal childhood development and a normal adolescence have been interrupted by recent events. The implications of these widespread problems for education and health care services are enormous throughout the countries of the former Yugoslavia. Mental health professionals in all of these countries, who had well-developed frameworks for providing mental health services prior to the war, must now address the disruption of care and the destruction of facilities in many areas, as well as shortages of resources.

Despite these circumstances, mental health and psychiatric services have been maintained in many regions, and programs have been developed even under the present conditions of war and economic difficulties. Various centers have developed innovative screening and intervention programs that use not only psychiatrists but also other professionals with wide access to children, including teachers, psychologists, and pediatricians.

There is concern, however, that the challenge presented by mental health problems in these regions may be greater in the future. In this regard it is important to realize that both already established psychosocial programs and community resources will require long-term support from local governments and from the international community.

An additional concern in the mental health field is recognition of the need for supporting the caregivers themselves. Professionals and volunteers alike have been working under grave difficulties with major case loads, and these conditions can traumatize these individuals. It was clear from the information presented at the workshop that any program set up by mental health professionals must also take into consideration the help needed for the caregivers themselves.

There is a great opportunity for learning from the experiences of these countries, but research in this field needs to be integrated with intervention services as well as with assisting those affected by the war. With the large

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numbers of affected children, appropriate follow-up programs could help to answer questions about the scale and scope of the impacts of war on children, families, and future generations.

CHILD PROTECTION

The duty of physicians to render care and protection to patients under all circumstances is expressed in existing instruments including international conventions and professional codes of ethics. Many professional codes include specific reference to the need to protect and care for children, who require greater attention in times of stress and difficult circumstances because of their vulnerability and dependent status. Specific attention to the need to safeguard the human rights of children is included in many international instruments as well, the most pertinent of which is the International Convention on the Rights of the Child (United Nations General Assembly, 1989; Verhellen, 1994; Institute of Medicine, 1994). Although the vast majority of nations have now signed or ratified the International Convention on the Rights of the Child, and although all of the world's doctors should be governed by codes of professional ethics, effective protection of children in the countries of former Yugoslavia and in many other parts of the world has not occurred. This failure to protect children has an enormous negative impact on child health in the form of direct injuries sustained by children; effects on psychological well-being; the destruction of family, community, and child life; and the disruption of systems of health care and education.

Protection of children in difficult circumstances was an important topic at the workshop. Discussions concerned the codes and instruments that might be applicable to the protection of children, the reasons that effective protection of children has not occurred, and possible solutions to this problem. Workshop participants examined the relevance of the Convention, professional codes of ethics, and other related efforts to protect children in difficult circumstances as well as the roles of pediatricians and children's doctors in these situations.

Evolution of the Concept of the "Rights of the Child"

Until the end of the Middle Ages there seemed to be little social awareness of children as a group. Many children died in early life; their main task was to survive past the age of 6 or 7 years, when they were considered adults. In this system, children were regarded as the father's private property and treated like any other goods. During the Enlightenment of the eighteenth century children were considered differently, as the future makers of an enlightened society. They

were thus turned into "not-yet" human beings who did not yet exist but who someday would be of great importance to the state. Children were not perceived to have rights in the present but only in the future. The world entered the twentieth century with this image of children.

Essentially three main generations of human rights exist at present. The first came about after the American and French Revolutions and evolved into the concept of traditional civil and political rights, such as the right to freedom of assembly, the right to freedom of opinion, and so forth. These first-generational rights provided a defense against sovereign rulers and implied that the state should abstain from interference in the private lives of its citizens. The second generation of human rights, which has come about more recently, deals with economic, social, and cultural rights, such as the right to a minimum income, work, health care, education, and leisure. These second-generational rights imply that the state, in fact, bears some responsibility for the lives of its citizens. Current thinking has now begun to address a third generation of human rights, the so-called solidarity rights, such as the right to peace, the right to a healthy environment, the right to cultural integrity, and so forth.

Over the last two decades there have been profound changes in the perceived status of children. Recent human rights movements have viewed children as full-fledged individuals with their own human rights and with competence to exercise them independently, although this latter point is a subject of considerable controversy. The status of the "not-yet" human being has been challenged in a number of ways. This new way of thinking has stimulated considerable controversy concerning the competence of children to exercise their rights independently.

The main aim of recent human rights movements has been to consider children as full-fledged individuals with their own human rights and with competence to exercise them independently.

The Convention on the Rights of the Child

The Convention on the Rights of the Child was adopted by the U.N. General Assembly on November 20, 1989, 30 years after the adoption of the Declaration on the Rights of the Child and 10 years after the International Year of the Child (Verhellen, 1994; Institute of Medicine, 1994; United Nations General Assembly, 1989). This Convention is the legal instrument that has evolved from the moral obligation defined in the 1924 Geneva Declaration and the 1959 Declaration on the Rights of the Child.

Within 1 year the required number of United Nations member states had ratified it, and on September 2, 1990, the Convention entered into force. At

present 171 nations of the world have ratified or signed this Convention; only 19 have not, including the United States.

The United Nations Convention on the Rights of the Child reflects wide changes in society. This Convention is made up of an extensive preamble (13 paragraphs) and 54 separate articles. Articles 1 to 41 cover substantive matters, defining the rights of the child and the obligations of state parties ratifying the Convention. Articles 42 to 55 regard procedures for monitoring implementation of the Convention, and Articles 46 to 54 contain formal provisions governing entry into force of the Convention. The Convention is summarized in Appendix C.

Workshop participants agreed that although all of the countries of the former Yugoslavia have now ratified this Convention, violations of this document have been frequent in the wars among the countries. Specific provisions of the Convention that are particularly applicable to children caught in the wars of the countries of the former Yugoslavia and wars elsewhere include the articles that address the age definition of children, which is an important consideration in the collection of statistics. The Convention recognizes children as all persons under age 18 (Article 1) or under 15 in the case of military service (Article 38). In collecting trauma statistics, however, the United States applies a standard of 14 years or younger for the age of the child; older children are subject to different kinds of accidents (automobile accidents, alcohol and drug abuse, and so on). Similarly, in Croatia and Bosnia-Herzegovina, adolescent boys are at times serving as soldiers and are also subject to different kinds of trauma.

Other articles within the Convention address the state's obligation to protect children from any form of discrimination and to take positive action to promote children's rights, the state's obligation to provide a child with adequate care when the parents fail to do so or cannot do so, and the state's obligation to use its authority and resources to implement all of the rights contained in the Convention.

The Convention states that every child has the inherent right to life, that the state has an obligation to ensure the child's survival and development, and that every child has the right to a name and a nationality and to know and be cared for by his or her parents.

The Convention requires the state to protect a child's name, nationality, and family ties; to respect the child's right to freedom of thought, conscience, and religion; and to protect the child from interference with privacy, family, and home. Furthermore, the state shall protect the child from all forms of maltreatment by parents or others, establish appropriate social programs for the prevention of abuse and for the treatment of its victims, and provide special protection for children deprived of family environments. Disabled children have the right to special care, education, and training so that they may enjoy full and decent lives.

With respect to refugee children, Article 22 states that special protection shall be granted to refugee children or to children seeking refugee status. The Convention states that the child has the right to the highest standard of health and medical care attainable, with special emphasis on the provision of primary and preventive health care and the reduction of infant mortality, and that every child has the right to a standard of living adequate for his or her physical, mental, spiritual, moral, and social development.

Additional articles address the child's right to education and schooling; the rights of children of minority communities to enjoy their own culture and practice their own religions and languages; and the child's right to leisure, play, and participation in cultural activities.

The Convention states that the state shall protect children from sexual exploitation and abuse; that no child shall be subjected to torture, cruel treatment or punishment, unlawful arrest, or deprivation of liberty; and that the state shall ensure the protection and care of children who are affected by armed conflict as described in relevant international law. In addition, Article 39 states that the state has an obligation to ensure that child victims of armed conflict, torture, neglect, maltreatment, or exploitation receive appropriate care for their recovery and social reintegration.

In conclusion, the Convention states that if any standards set in applicable national and international law relevant to the rights of the child are of a higher standard than those set forth in the Convention on the Rights of the Child, then the higher standard shall always apply.

Translation of human rights declarations into legally binding treaties requires both monitoring and effective means of enforcement (Verhellen and Spiesschaert, 1994). States that ratify the Convention are obliged to make the rights contained in the Convention widely known to both adults and children. They are also required to submit within 2 years after ratification a country report on the status of children's rights, and follow-up country reports are required every 5 years thereafter. These reports are evaluated and distributed by the Committee on the Rights of the Child, which can also request that special studies be undertaken. All countries of the former Yugoslavia have ratified the Convention, and such country reports will be sought in the near future.

Codes of Professional Ethics

Throughout history the relief of pain and suffering and the treatment of disease and disability have been viewed as being very important by society. Physicians who perform these crucial functions have been given power and privilege and have received the trust and dependence of their patients. This gives physicians and health care workers very special responsibilities.

The codes of professional ethics of physicians specifically support the protection of children as human beings. Professional guidelines for physicians' conduct have existed in most societies, although modern medical practice presents new bioethical dilemmas with every technological and scientific advance. The traditions of medical practice have placed greater emphasis on respect for the individual patient's decisions and integrity, even if the patient is a child. There is no universal agreement about the age at which a child should enter into decisions about treatment or about being used as the subject of research. In the United States, the age of 7 has been selected as an age at which a child can give assent, which means that a child needs to understand treatments or experiments and that the child's views must be taken into account in making decisions.

The oath of Hippocrates, one which physicians all over the world take when they enter medical practice, dates back more than 2,300 years. It states, among other things, "I will keep them [the sick] from harm and injustice." Hippocrates also addresses both confidentiality and the relationship of physicians to their colleagues. Patient confidentiality is of particular importance in times of war, regardless of the politics of either the patient or the doctor.

Centuries after Hippocrates, Maimonides, a physician to the Sultan Saladin in the twelfth century, also had a great influence on medical ethics. In his prayer, Maimonides says, "Preserve the strength of my body and of my soul that they ever be ready to help and support rich and poor, good and bad, and enemy as well as friend." From this tradition has evolved the obligation of the physician to treat anyone who has a need to be treated without discrimination.

Different groups and associations have developed many versions of codes of ethics and professional guidelines. The Declaration of Geneva of the World Medical Association represents a modernized version of the Hippocratic oath (Stover and Nightingale, 1985). An Islamic code of medical ethics dates back to 1981. Medical associations of many countries also have their own codes. In 1980 the American Medical Association produced its code, which is patterned after the Hippocratic oath. The British Medical Association took 100 years between the mid-nineteenth and mid-twentieth centuries to produce a 16-page document that addresses medical ethics; in recent years, the British Medical Association has been active in promoting the professional responsibility of physicians worldwide.

Most codes of professional ethics for physicians cover similar points:

- The professional duty of a physician must be guided by the best interests of the patient without discrimination.
- The confidentiality of the patient must be protected.
- Both health and life must be preserved in the best interests of the patient.

- The physician must know the limitations of his or her knowledge and seek consultation when needed.
- The physician must both teach and continue to learn throughout his or her professional life.
- The physician must behave honestly and place concern for the needs and well-being of the patient rather than concerns for his or her own person first.
- The physician must communicate with colleagues. (The workshop described here provides an excellent example in which colleagues from places in very difficult circumstances communicate.)

The declaration of the World Medical Association emphasizes that the same regulations and guidelines apply in times of armed conflict as in times of peace. In times of armed conflict, it is completely unethical for a physician to act in any manner not in the patient's interest, even if the patient is an enemy.

The 1975 Declaration of Tokyo, also from the World Medical Association, deals with a difficult subject—the participation of physicians in torture—and prohibits any physician from participating in this activity. Yet a publication of the British Medical Association, *Medicine Betrayed* (British Medical Association, 1993), documents the breach of this principle in a number of countries all over the world.

The Roles of Professional Organizations

The international community of physicians and their associations can be important influences in supporting physician colleagues and their families whenever physicians are being pressured to participate in unethical behavior such as torture, breach of confidentiality, falsification of death certificates, falsification of health data, or other abuses for political purposes (Stover and Nightingale, 1985). Publicity regarding such abuses can help generate support from areas outside the country. Outside pressure can make a difference, although the risk remains for those physicians who withstand the pressure but remain in their country. Violations of professional ethics can be policed by the medical profession when necessary.

Global consensus on the ethical behavior of physicians is particularly critical when speaking of physicians who care for children, because children are vulnerable and cannot defend themselves. Physicians can serve as advocates not only for their own patients (children in their own vicinities) but also for children everywhere. This includes protection of the human rights of children and fulfilling their obligations as physicians to deliver care to those in their

community who may be in great need. Physicians are often in a position to be the first to document and see abuses against children.

The ethical conduct of physicians is vital to the protection of the human rights of their patients. Yet, medical education often neglects instruction in medical ethics and the role of medical professionals in the protection of human rights.

How can physicians help to protect the rights of children within the guidelines of ethical behavior for their professions? One method is to document and publish abuses, including the physical and psychological impacts of war on children. Credible documentation is extremely important, especially the use of accurate data and case histories. Documented cases and reliable data need to be distinguished from impressions and rumors, particularly since health data may be used for political purposes.

Medical associations have a responsibility to ensure the accuracy and validity of health data in their own countries so that they cannot be distorted for political purposes. An example of how the presentation of data can be a violation of human rights occurred in Chile during the height of the Pinochet regime, in which the government Ministry of Health published a set of figures about child health. The Chilean Medical Association collected its own data and published a set of figures that was quite different. Chilean children were suffering much more than the government would admit, yet the government data often determined the level of aid that the children of Chile received.

Medical associations can do a great deal to protect physicians who are trying to behave ethically under difficult circumstances by documenting abuses. Outside medical groups can often publicize abuses more safely than an individual or group of physicians who reside within the country where the violations occur.

Medical associations also have a responsibility to address violations of medical ethics by their own members, such as participation in torture, rape, falsification of records, and breaches of confidentiality.

The formation of linkages, or networks, of health professionals can be an important strategy in addressing human rights concerns. Meetings such as the one described here, where physicians from different areas exchange views and information, are extremely valuable opportunities to reflect on the challenges and resources that affect professional ethics in difficult situations. Such linkages can be extended to medical associations, both national and international. Forums for discussions of these issues provide an opportunity for physicians and students to examine exemplary practices for decision making and behavior.

In considering the health needs of children in regions characterized by war and violence, the conduct of research requires respect for the rights of the subjects of research. The guidelines recently published by the Council for International Organizations of Medical Sciences are widely accepted and can be

helpful in this regard. Physicians themselves also have a responsibility to communicate their needs to improve the status of their own patients.

Summary

The participants observed that violations of the rights of children in the war in the countries of the former Yugoslavia and in other wars affected their health and were thus the proper concern of pediatricians. The participants explored ways to act effectively as a conscience for children in the world today, building on the foundation established by the Convention on the Rights of the Child. All of the countries of the former Yugoslavia are responsible for the rights of the children within their own national boundaries. However, attention to the rights of children should transcend national boundaries and should apply to the children of other states as well. For example, the U.S. participants commented that as advocates for children, health professionals in the United States should seek ways to implement the Convention both within the United States and elsewhere.

This matter of collective responsibility for the health and rights of all children was emphasized repeatedly. Hope was also expressed that the lessons learned about the protection of children in the countries of the former Yugoslavia could be applied to children in other war zones. The Convention represents an important vision of the future as well as an innovative legal instrument in implementing the achievement of children's rights. Pediatricians can serve as the consciences for adults regarding children and children's rights and, by making violations visible to the international community, can achieve the realization of better efforts on behalf of children and their families.

Findings

The roles of physicians as the conscience of the health community, with specific responsibilities to patients and their families, are not yet well understood or defined. Such roles need to be clearly delineated in times of stress and under conditions such as war, when there may be a blurring or confusion of roles, for in these times the ethical responsibilities of physicians become even more important. The formulation of ethical principles can serve as an important guide for professional activities and behavior regarding refugees, prisoners of war, and all other vulnerable populations. Many workshop participants observed that they had received little or no instruction about ethical issues and limited experience with implementing these principles in clinical settings and in practical situations, which are important to social learning through modeling.

Certain general principles emerged in the workshop discussions, such as the need to keep children with their parents whenever possible, the need to protect children within their home communities whenever possible, and the importance of maintaining basic health, educational, and social service systems for children under conditions of great adversity.

The participants examined how these principles might be implemented during the course of dislocations and upheavals, how professional roles can be exercised to minimize the trauma, and how the lives of families and children can be reintegrated within a context in which their growth and development can proceed in a wholesome fashion. The participants also observed the importance of developing social strategies to foster the interaction of knowledge and policy in serving the needs of children.

The strengths and limitations of professional organizations as advocates for children were discussed, including groups such as WHO, UNICEF, the Union of National European Pediatric Societies and Associations, the International

Pediatric Association, and the American Academy of Pediatrics. The participants explored the importance of improving communications among themselves and the organizations they represented to reduce the professional isolation experienced by many colleagues under conditions of war and dislocation. In particular, the group proposed that the participants reconvene in the future to continue the process of communication and to sustain the relationships and exchanges that occurred during the course of the workshop.

The Convention of the Rights of the Child was recognized as a necessary, but not a sufficient, condition for achieving respect for the rights of children. Individual physicians, children's hospitals, clinics, and other institutions can play important roles as supporters and advocates of the provisions of the Convention and can raise the level of consciousness of colleagues and others in different countries about the relevant provisions of the Convention to child health and well-being.

In addition to these general findings, the following conclusions were developed in the workshop discussions.

General

1. The wars in the former Yugoslavia have exacted terrible tolls on children and families in all parts of the former Yugoslavia. Children and families have suffered as refugees, as displaced people within their own national borders, or as civilians remaining at home in or outside of war zones. The wars have affected children's physical health, mental health, day-to-day life, and hopes for the future. The wars have also extracted a heavy toll on the health care system through the loss of facilities and infrastructure, the loss of supplies and equipment, and the loss of physicians and nurses; and the economic hardships of war have resulted in fewer resources for health care.

2. Professional concerns about child health, child protection, and medical ethics can transcend political differences. Despite political divisions, pediatricians can cooperate in the interests of child health. For example, spare parts from Serbia were offered for non-functioning incubators in Zenica in Bosnia-Herzegovina, and children from Knin were invited to the Children's Hospital in Zagreb, Croatia.

3. Pediatricians and members of the medical and health professions have an important role to play in using their knowledge and influence to protect children and should use existing international documents such as the Convention on the Rights of the Child and professional documents such as codes of professional ethics.

4. Widespread violations of medical neutrality that are in direct violation of the Geneva Accords have occurred frequently in these wars. Such violations

include bombardment of hospitals and other health care facilities and direct attacks by bombardment or sniper fire on patients (including children), doctors, health care workers, and ambulances. Such violations were described in both Bosnia-Herzegovina and Croatia.

5. These wars have constituted a tragic laboratory for the study of the effects of war on children, families, civilians, and the health care system. Lessons from the events in the former Yugoslavia can be applied to similar situations elsewhere. There is an enormous opportunity for meaningful research and follow-up in designing and evaluating programs that address the health problems caused by these wars, but such efforts need to be integrated into services designed to benefit the subject populations.

6. Participants from all of the countries of the former Yugoslavia expressed strong feelings of academic isolation and a wish for renewed and increased professional linkages with colleagues and organizations in the world community. Assistance in obtaining books, journals, and other current information; assistance with attending appropriate international meetings; and the possibility of educational exchanges on various levels were all mentioned.

7. Several of the countries represented including Croatia, Macedonia, and Slovenia, have pediatric societies that belong to or that have applied for membership in the International Pediatric Association and the Union of National European Pediatric Societies and Associations. Participants from Bosnia-Herzegovina and Serbia also expressed an intent to organize pediatric societies. The participation of these societies in the International and the Union of National European Pediatric Societies and Associations and represents an important opportunity for building linkages to the world community of pediatricians that can benefit children in these regions.

8. Health care systems for children in the countries of the former Yugoslavia have many needs and require assistance. Consultation with the recipients of such aid regarding their needs, particularly the identification of needs as defined by current situations, will help to strengthen the capacities of the health care systems within the countries themselves. This approach is preferred to evacuating of large numbers of children and adults to be cared for elsewhere.

9. Adolescents have special needs, especially in the realm of mental health. The age standard of many international organizations often inhibits the development of services for the adolescent population.

10. Most resources of and planning performed by the health care community have been focused on survival. When the wars end there will be enormous problems in reconstructing the health care system and in rehabilitating, both physically and mentally, the child and adult victims of war.

Epidemiology

11. Documenting the facts on child health in difficult circumstances requires the selection of valid and practical indicators that reflect the status of health, consideration of the potential uses and abuses of data, and development of a capacity to measure health status under difficult circumstances. Existing techniques include the use of already existing data, opportunistic monitoring, and rapid surveys and appraisals. Community-based surveys can lead the way to in-depth health surveys. The collection of data can provide both the basis for planning as well as an opportunity for community involvement in formulating resources for child health.

12. Reliable data on child health since the onset of the wars are lacking in most areas of the former Yugoslavia. Standardized measures and data collections would be very useful to facilitate the analysis and comparison of regional data.

13. The identification of appropriate measurement instruments for data collection also needs attention. For example, malnutrition has not been a common problem in this part of the world, and available measures and techniques of measurement are not available. There may also be no available instruments to measure effectively the mental health impact of the prolonged trauma on children in these wars. Existing measures are often derived from the examination of the impacts of single catastrophic events.

Primary Health Care

14. Breakdowns in primary health care systems, preventive medicine, and maternal and child health care services in the countries of the former Yugoslavia require attention. Although regional differences exist, well-structured programs for the care of mothers and children have been widely disrupted.

15. Health care systems in all of the countries of the former Yugoslavia have been affected, especially in Bosnia-Herzegovina. Widespread destruction of health care facilities has occurred in Bosnia-Herzegovina and Croatia. Many doctors and nurses have left the war zones, and as a result few professionals and facilities are available to care for the increased numbers of sick and injured children and other civilians. Reconstruction of health care facilities will be a major problem when these wars end.

16. Although immunization programs have been compromised in some areas, there have been no major epidemics of diseases preventable by immunization. However, this area remains a serious concern if programs continue to deteriorate.

17. The widespread breakdown of sanitation and hygiene in the war zones and also in areas outside the war zones, including the loss of safe water supplies

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and a general lack of soap, detergent, and disinfectants, has resulted in increases in diarrheal disease, lice, and scabies in many areas.

18. Proposals for the privatization of the health care systems in several countries have generated concerns about the further disruption of maternal and child health care services and the role of pediatricians in a new system of medical services. The result could be a loss of universal health coverage, and the availability of treatment and medications could be based only on the ability to pay.

19. Available statistics indicate increasing infant mortality rates, increasing rates of premature births, and the increasing occurrence of birth defects. Birth rates are decreasing, and abortion rates are increasing. These changes have been most notable in Bosnia-Herzegovina, but were noted in all countries except Slovenia.

20. Maternal nutrition has been poor in many areas. In Mostar, Bosnia-Herzegovina, excessive weight gain by pregnant mothers, who eat the starchy foods available as relief aid, has been associated with an increase in complications during pregnancy, such as eclampsia.

21. No good figures are available concerning malnutrition in children, but many participants repeatedly mentioned the problem of hungry children. Adequate measurements of the nutritional states of children may be a problem.

22. Widespread shortages of supplies and equipment have resulted in a number of preventable deaths. The items in short supply include respirators for infants and oxygen; drugs such as insulin, anticonvulsants, and antibiotics; as well as vaccines. These shortages may result from the lack of supplies or the inadequate distribution of the available supplies.

23. Participants from Serbia reported that economic sanctions were a major cause of the declining state of health in their country. The economic strains of war also contribute to the diversion of resources from the health care system. The economic sanctions contain provisions for humanitarian aid, but these provisions are not thought to have been adequate or effective in allowing access to medical supplies and the basic commodities necessary for health and health care.

Trauma

24. War-related trauma has become a major cause of childhood mortality and morbidity, particularly in Bosnia-Herzegovina but also in Croatia. The majority of war-related deaths and injuries have resulted from direct shellings, bombardment, and sniper fire on civilians. Some snipers have targeted children.

25. Unexploded land mines, small arms, and other types of weapons pose a major health hazard to children, and a number of incidents of death and injury

have been reported in Croatia and Bosnia-Herzegovina, and in war areas such as Knin and Banja Luka. Such weapons are widely strewn about; children stumble on them and use them as toys when they find them. Indeed, children in most areas of the former Yugoslavia are playing war games. The full extent of this danger is not known; most children in Bosnia-Herzegovina, for example, have not been outside of shelters for any prolonged period of time. The mines and unexploded weapons there will remain a health hazard for children for years to come.

26. Maintaining adequate transport systems for trauma victims has posed an enormous problem. Transport has been disrupted by war and by the long circuitous routes necessitated by political divisions, resulting in increased mortality of wounded patients. Trauma teams have been sent to the front lines in both Croatia and Bosnia-Herzegovina.

27. Trauma is an important cause of mortality and morbidity for children all around the world, and a background of similar trauma also exists in all of the countries of the former Yugoslavia. Those who are responsible for trauma care for children require special training to understand the care needs of children that differ from those of adults. The collaboration of pediatricians and surgeons in the early management of trauma is essential. In the future the rehabilitation of trauma victims will require increased attention. Prevention of trauma is another important consideration, especially with regard to safety programs, including mine and weapon removal efforts, in the countries of the former Yugoslavia.

28. Children directly affected by trauma are not the only victims of these wars. Routine therapy for children affected with common conditions such as cleft lip and palate and congenitally dislocated hips has often been deferred because of the load of trauma patients in selected areas, including Croatia and Bosnia-Herzegovina. Such children, even though they have treatable conditions, may suffer long-lasting ill-effects because of their lack of timely care. Other medical conditions such as childhood cancer, congenital heart disease, and malformations such as esophageal atresia have been impossible to manage in many areas.

29. Evacuation of wounded children is not always the best solution to their care. It is often preferable to strengthen the local care systems available in the home area. If children are evacuated, members of their immediate families need to accompany them.

30. There is a great need for surgical services, particularly in Bosnia-Herzegovina. Surgeons with special technical skills such as microsurgery and plastic surgery and equipment such as external fixation devices are needed. However, it is essential that recipients be consulted about their needs before developing any program of assistance.

Acute and Chronic Illnesses

31. Morbidity and mortality from both acute and chronic illnesses in children have increased as a result of the war.

32. Acute infectious diseases have included gastroenteritis and hepatitis. Several contained epidemics of salmonella have been reported, but no typhus or cholera has been reported. Infestations with scabies and lice have also increased.

33. Concerning chronic infectious diseases, there is concern that the incidence of tuberculosis may increase, at least among adults. BCG vaccine, purified protein derivative, X-ray film, and laboratory facilities for detecting mycobacteria in sputum are lacking, and antituberculous drugs are in short supply. Human immunodeficiency virus infection and AIDS are also of concern, particularly given the history of rape and sexual abuse in these wars. Several cases of HIV infection are already known in Sarajevo.

34. Diabetes mellitus, asthma, seizure disorders, malignancies, congenital heart disease, and birth defects have all posed problems because of either decreased drug availability or a decreased capacity of the health care system to provide care. Factors 8 and 9 are not available for individuals with hemophilia. Rheumatic fever remains present, although it is not clear whether this is an increasing problem. In spite of attendant problems, evacuation of children for care of complex conditions such as congenital heart disease may be necessary when adequate care is not available at home.

35. An increase in nosocomial infections was reported in Serbia. Surprisingly, salmonella was mentioned as one of the offending organisms.

36. Deficiency diseases such as rickets, iodine-deficient goiter, and iron deficiency anemia were noted in several areas.

37. Widespread shortages of drugs including insulin, antibiotics, asthma medications, anticonvulsants, and simple preparations such as aspirin, iron, iodine, and vitamin D have been reported. These shortages may be related to supply or distribution problems.

Mental Health

38. Mental health problems pose a massive health concern in all of the countries of the former Yugoslavia and may prove to be the most devastating health problem resulting from the wars. There is great concern that after the wars mental health problems will emerge as an even larger problem than they seem at present.

39. The majority of children living in the countries of the former Yugoslavia seem to be at risk of mental health problems. This includes both those children who are directly affected by war and those who are living under difficult

circumstances in a traumatized society. Children from many areas now play war games, and exhibit a pervasive sadness.

40. The effects of prolonged exposure to multiple stresses, as opposed to those of a single catastrophic event, appear to be additive, but these effects are poorly understood. Additional research and new measurement instruments are needed to determine the dose and duration of exposure to severe stress and the outcomes of these experiences. All areas of the lives of children living in war zones have suffered terribly, including the disruption of education and the social order.

41. A rise in violent and delinquent behavior, drug usage, and sexual promiscuity has been noticed in adolescents in a number of countries. Prostitution has been reported in girls as young as 11 or 12 years. Suicide has also become a problem in children.

42. The widespread nature of mental health problems has caused mental health professionals in these regions to devise new ways of therapy that entail the training and utilization of community professionals such as teachers.

Child Protection

43. All countries of the former Yugoslavia have ratified the Convention on the Rights of the Child, but this Convention is being widely violated. Within the next few years all countries will be required to present a country report to the Commission on the Convention in Geneva, offering an opportunity for the discussion of problems.

44. Codes of professional ethics of physicians and pediatricians have not served effectively to protect children. Adherence to codes of medical ethics and professional standards are extremely important in times of war.

45. Pediatricians bear a collective responsibility for protecting the children in their regions, and indeed throughout the world. Pediatricians have an important role to exercise in educating policymakers and service providers about the special needs of children in these regions. This role requires careful documentation and the reporting of abuses.

46. The dissemination of the Convention in children's hospitals and incorporation of the Convention into the curricula of medical students and residents are important ways of increasing public awareness of its existence and purpose.

47. The teaching of medical and professional ethics is an important component of medical education, particularly when incorporated into clinical settings.

Professional Development

48. The professional isolation of colleagues in these regions requires the identification of ways in which collegial ties can be established both internally and with the world medical community.

49. Professional development in these regions will require access to current scientific and health information and participation in the international academic community. Practical needs for teaching and training in professional areas not adequately represented in the countries of the former Yugoslavia also need attention.

Next Steps

The development of the network of pediatricians and other health professionals involved in the workshop is an important step in improving the health and welfare of children in the republics of the former Yugoslavia.

- Participants expressed a strong interest in continuing their discussions and in meeting again in the near future to examine progress in the areas of concern described in this report, including:

  — Epidemiology and development of methods for standardized data collection;
  — Definition of needs for the restoration of child health;
  — Programs to support child mental health;
  — Roles of pediatricians and children's doctors in the protection of children under difficult circumstances; and
  — Redevelopment of professional connections with European and international pediatric societies.

An interim meeting is planned for the fall of 1994, and an anniversary meeting is planned in the spring of 1995.

- The development of pediatric societies through the region would be an important step toward the professional organization of physicians in these regions, especially if these societies are able to attain membership in the International Pediatric Association and the Union of National European Pediatric Societies and Associations. Slovenia, Croatia, and Macedonia already have functioning pediatric societies. Societies are currently being formed in Bosnia-Herzegovina and Serbia.

- Individual members of the organizing committee plan to explore ways to implement appropriate exchange programs, including assistance with academic support such as books and journals and travel support for international meetings in both Europe and the United States.
- The workshop participants will also seek to promote awareness of the International Convention on the Rights of the Child in children's hospitals, pediatric departments, and pediatric clinics.

The role of the international pediatric community as advocates for the health and rights of all children, with particular emphasis on the protection of children in difficult circumstances, is one that will require renewed commitment and diligence. The report of the workshop on the effects of war on the children of the former Yugoslavia is an important step in exercising this role.

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Appendixes

A

Advisors to the Organizing Committee

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Dr. Ninaslava Vucak
Chief
Pediatric Intensive Care
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C

Organizational Summaries

National Academy of Sciences (NAS)

James Wyngaarden, Foreign Secretary; Mary Ellen Avery (member)

The National Academy of Sciences is a private, nonprofit, self-perpetuating society of distinguished scholars engaged in scientific and engineering research, dedicated to the furtherance of science and technology and to their use for the general welfare. Upon the authority of the charter granted to it by Congress in 1863, the Academy has a mandate that requires it to advise the federal government on scientific and technical matters.

Institute of Medicine (IOM)

Mary Ellen Avery, Robert Haggerty, Birt Harvey, Samuel Katz, Elena O. Nightingale, Jane G. Schaller, and James Wyngaarden (members)

The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research and education.

National Research Council (NRC)

The National Research Council was organized by the National Academy of Sciences in 1916 to associate the broad community of science and technology with the Academy's purposes of furthering knowledge and advising the federal government. Functioning in accordance with general policies determined by the Academy, the Council has become the principal operating agency of both the National Academy of Sciences and the National Academy of Engineering in providing services to the government, the public, and the scientific and engineering communities. The Council is administered jointly by the National Academy of Sciences, the National Academy of Engineering, and the Institute of Medicine.

In a typical year, the academy complex has more than 9,000 scientists and other professional participants volunteering in the work of nearly 950 committees. The work of many of these committees is related to the health and development of children throughout the world. Past and current examples of these committees include the Panel on the Mental Health of Children and Adolescents, Children's Vaccine Initiative, the Board on Children and Families, and the Steering Committee of the National Forum on the Future of Children and Families.

International Pediatric Association (IPA)

Robert Haggerty, Executive Director

The International Pediatric Association is an organization of 140 national pediatric societies, eight regional pediatric societies (such as the Union of National European Pediatric Societies and Associations), and seven international subspecialty pediatric societies. It pursues the ambitious goal of improving the health of children everywhere in the world through education, a triennial world congress (the next one is in Cairo in September 1995), regional workshops, and a journal entitled *International Child Health: A Digest of Current Information*.

Union of National European Pediatric Societies and Associations (UNEPSA)

Eberhardt Schmidt, Secretary General

The Union of National European Pediatric Societies and Associations was founded as a federation of pediatric societies in 1975, and was designed to build a bridge between East and West in Europe in the interest of child health through conferences and mutual personal contacts across the Iron

Curtain. This concept proved to be successful because by 1989 25 member societies had joined UNEPSA. With the opening of European borders and the independence of new European states, 34 national societies now constitute UNEPSA, which has now transformed itself to a Forum for Planning and Development of European Pediatrics. This is achieved in annual conferences on various pediatric standards in close cooperation with activities of the European community which encloses 17 states on the way to harmonize pediatric training and standards. UNEPSA is affiliated with the International Pediatric Association.

The American Academy of Pediatrics (AAP)
Dr. Birt Harvey, Former President

The American Academy of Pediatrics is an organization whose members consist of U.S. pediatricians and pediatric medical and surgical specialists. Its 46,000 members dedicate their efforts and resources to the health, safety, and well-being of infants, children, and adolescents. The goals of the Academy include advocacy for children, access to health care, research and service to children, public education, professional education, and representation for pediatricians.

Since a major goal is professional education, the Academy offers continuing education courses, biannual scientific meetings, seminars, and publications and statements from committees and section. The Academy also publishes the monthly journal *Pediatrics* and *Pediatrics in Review* as well as periodic manuals on such topics as infectious diseases, school health, hospital care, and nutrition.

Although the primary focus of the Academy is on children in the United States, it is concerned with the health and well-being of children throughout the world. To further this objective the Academy has a Committee on International Child Health and a Subcommittee on Human Rights that recommend Academy involvement in projects and activities in other nations. *Pediatrics* is published monthly in overseas editions in Italian, Spanish, Arabic, and Portuguese. English language editions of *Pediatrics* are also published in India and Japan. *Pediatrics in Review* and a manual on infectious diseases are translated into Spanish and are disseminated throughout Latin America.

D

International Convention on the Rights of the Child

Adopted by the General Assembly of the United Nations on 20 November 1989

Unofficial Summary of Main Provisions

PREAMBLE

The preamble recalls the basic principles of the United Nations and specific provisions of certain relevant human rights treaties and proclamations. It reaffirms the fact that children, because of their vulnerability, need special care and protection, and it places special emphasis on the primary caring and protective responsibilities of the family. It also reaffirms the need for legal and other protection of the child before and after birth, the importance of respect for the cultural values of the child's community, and the vital role of international cooperation in securing children's rights.

DEFINITION OF A CHILD (ARTICLE 1)

A child is recognized as a person under 18 years of age, unless national laws recognize the age of majority earlier.

NONDISCRIMINATION (ARTICLE 2)

All rights apply to all children without exception. It is the state's obligation to protect children from any form of discrimination and to take positive action to promote their rights.

BEST INTEREST OF THE CHILD (ARTICLE 3)

All actions concerning the child shall take full account of his or her best interests. The state shall provide the child with adequate care when parents, or others charged with that responsibility, fail to do so.

IMPLEMENTATION OF RIGHTS (ARTICLE 4)

The state must do all that it can to implement the rights contained in the Convention.

PARENTAL GUIDANCE AND THE CHILD'S EVOLVING CAPACITIES (ARTICLE 5)

The state must respect the rights and responsibilities of parents and the extended family to provide guidance for the child which is appropriate to her or his evolving capacities.

SURVIVAL AND DEVELOPMENT (ARTICLE 6)

Every child has the inherent right to life, and the state has an obligation to ensure the child's survival and development.

NAME AND NATIONALITY (ARTICLE 7)

The child has the right to a name at birth. The child also has the right to acquire a nationality and, as far as possible, to know his or her parents and be cared for by them.

PRESERVATION OF IDENTITY (ARTICLE 8)

The state has an obligation to protect, and, if necessary, reestablish basic aspects of the child's identity. This includes name, nationality, and family ties.

SEPARATION FROM PARENTS (ARTICLE 9)

The child has a right to live with his or her parents unless this is deemed to be incompatible with the child's best interests. The child also has the right to maintain contact with both parents if separated from one or both.

FAMILY REUNIFICATION (ARTICLE 10)

Children and their parents have the right to leave any country and to enter their own country for purposes of reunion or the maintenance of the child-parent relationship.

ILLICIT TRANSFER AND NONRETURN (ARTICLE 11)

The state has an obligation to prevent and remedy the kidnapping or retention of children abroad by a parent or third party.

THE CHILD'S OPINION (ARTICLE 12)

The child has the right to express his or her opinion freely and to have that opinion taken into account in any matter or procedure affecting the child.

FREEDOM OF EXPRESSION (ARTICLE 13)

The child has the right to express his or her views, obtain information, and make ideas or information known, regardless of frontiers.

FREEDOM OF THOUGHT, CONSCIENCE, AND RELIGION (ARTICLE 14)

The state shall respect the child's right to freedom of thought, conscience, and religion, subject to appropriate parental guidance.

FREEDOM OF ASSOCIATION (ARTICLE 15)

Children have a right to meet with others and to join or form associations.

PROTECTION OF PRIVACY (ARTICLE 16)

Children have the right to protection from interference with privacy, family, home, and correspondence and from libel or slander.

ACCESS TO APPROPRIATE INFORMATION (ARTICLE 17)

The state shall ensure the accessibility to children of information and material from a diversity of sources, and it shall encourage the mass media to disseminate information that is of social and cultural benefit to the child and to take steps to protect him or her from harmful materials.

PARENTAL RESPONSIBILITIES (ARTICLE 18)

Parents have joint primary responsibility for raising the child, and the state shall support them in this. The state shall provide appropriate assistance to parents in child-raising.

PROTECTION FROM ABUSE AND NEGLECT (ARTICLE 19)

The state shall protect the child from all forms of maltreatment by parents or others responsible for the care of the child and establish appropriate social programs for the prevention of abuse and the treatment of victims.

PROTECTION OF A CHILD WITHOUT FAMILY (ARTICLE 20)

The state is obliged to provide special protection for a child deprived of the family environment and to ensure that appropriate alternative family care or institutional placement is available in such cases. Efforts to meet this obligation shall pay due regard to the child's cultural background.

ADOPTION (ARTICLE 21)

In countries where adoption is recognized and/or allowed, it shall only be carried out in the best interests of the child, and then only with the authorization of competent authorities and safeguards for the child.

REFUGEE CHILDREN (ARTICLE 22)

Special protection shall be granted to a refugee child or to a child seeking refugee status. It is the state's obligation to cooperate with competent organizations that provide such protection and assistance.

DISABLED CHILDREN (ARTICLE 23)

A disabled child has the right to special care, education, and training to help him or her enjoy a full and decent life in dignity and to achieve the greatest degree of self-reliance and social integration possible.

HEALTH AND HEALTH SERVICES (ARTICLE 24)

The child has a right to the highest standards of health and medical care attainable. States shall place special emphasis on the provision of primary and preventive health care, public health education, and the reduction of infant mortality. They shall encourage international co-operation in this regard and strive to see that no child is deprived of access to effective health services.

PERIODIC REVIEW OF PLACEMENT (ARTICLE 25)

A child who is placed by the state for reasons of care, protection, or treatment is entitled to have that placement evaluated regularly.

SOCIAL SECURITY (ARTICLE 26)

The child has the right to benefit from social security including social insurance.

STANDARD OF LIVING (ARTICLE 27)

Every child has the right to a standard of living adequate for his or her physical, mental, spiritual, moral, and social development. Parents have the primary responsibility to ensure that the child has an adequate standard of living. The state's duty is to ensure that this responsibility can be fulfilled, and is. State responsibility can include material assistance to parents and their children.

EDUCATION (ARTICLE 28)

The child has a right to education, and the state's duty is to ensure that primary education is free and compulsory, to encourage different forms of secondary education accessible to every child, and to make higher education available to all on the basis of capacity. School discipline shall be consistent with the child's rights and dignity. The state shall engage in international co-operation to implement this right.

AIMS OF EDUCATION (ARTICLE 29)

Education shall aim at developing the child's personality, talents, and mental and physical abilities to the fullest extent. Education shall prepare the child for an active adult life in a free society and foster respect for the child's parents, his or her own cultural identity, language and values, and the cultural backgrounds and values of others.

CHILDREN OF MINORITY OR INDIGENOUS POPULATIONS (ARTICLE 30)

Children of minority communities and indigenous populations have the right to enjoy their own culture and to practice their own religion and language.

LEISURE, RECREATION, AND CULTURAL ACTIVITIES (ARTICLE 31)

The child has the right to leisure, play, and participation in cultural and artistic activities.

CHILD LABOR (ARTICLE 32)

The child has the right to be protected from work that threatens his or her health, education, or development. The state shall set minimum ages for employment and regulate working conditions.

DRUG ABUSE (ARTICLE 33)

Children have the right to protection from the use of narcotic and psychotropic drugs and from being involved in their production or distribution.

SEXUAL EXPLOITATION (ARTICLE 34)

The state shall protect children from sexual exploitation and abuse, including prostitution and involvement in pornography.

SALE, TRAFFICKING, AND ABDUCTION (ARTICLE 35)

It is the state's obligation to make every effort to prevent the sale, trafficking, and abduction of children.

OTHER FORMS OF EXPLOITATION (ARTICLE 36)

The child has the right to protection from all forms of exploitation prejudicial to any aspects of the child's welfare not covered in Articles 32, 33, 34, and 35.

TORTURE AND DEPRIVATION OF LIBERTY (ARTICLE 37)

No child shall be subjected to torture, cruel treatment or punishment, unlawful arrest, or deprivation of liberty. Both capital punishment and life

imprisonment without the possibility of release are prohibited for offenses committed by persons under 18 years of age. Any child deprived of liberty shall be separated from adults unless it is considered in the child's best interests not to do so. A child who is detained shall have legal and other assistance as well as contact with the family.

ARMED CONFLICTS (ARTICLE 38)

State Parties to the Convention shall take all feasible measures to ensure that children under 15 years of age have no direct part in hostilities. No child under 15 years of age shall be recruited into the armed forces. States shall also ensure the protection and care of children who are affected by armed conflict as described in relevant international law.

REHABILITATIVE CARE (ARTICLE 39)

The state has an obligation to ensure that child victims of armed conflicts, torture, neglect, maltreatment, or exploitation receive appropriate treatment for their recovery and social reintegration.

ADMINISTRATION OF JUVENILE JUSTICE (ARTICLE 40)

A child in conflict with the law has the right to treatment that promotes the child's sense of dignity and worth, takes the child's age into account, and aims at his or her reintegration into society. The child is entitled to basic guarantees as well as legal or other assistance for his or her defense. Judicial proceedings and institutional placements shall be avoided whenever possible.

RESPECT FOR HIGHER STANDARDS (ARTICLE 41)

Wherever standards set in applicable national and international law relevant to the rights of the child are higher than those in this Convention, the higher standards shall always apply.

IMPLEMENTATION AND ENTRY INTO FORCE (ARTICLES 42–54)

The provisions of Articles 42 to 54 notably foresee:

(i) The state's obligation to make the rights contained in this Convention widely known to both adults and children.

(ii) The setting up of a Committee on the Rights of the Child composed of 10 experts, which will consider reports that State Parties to the Convention are to submit 2 years after ratification and every 5 years thereafter. The Convention enters into force—and the Committee would therefore be set up—once 20 countries have ratified it.

(iii) State Parties to the Convention are to make their reports widely available to the general public.

(iv) The Committee may propose that special studies be undertaken on specific issues relating to the rights of the child, and may make its evaluations known to each State Party concerned as well as to the U.N. General Assembly.

(v) In order to "foster the effective implementation of the Convention and to encourage international cooperation," the specialized agencies of the United Nations—such as the International Labour Organization, World Health Organization, and United Nations Educational, Scientific, and Cultural Organization—and the United Nations Children's Fund would be able to attend the meetings of the Committee. Together with any other body recognized as "competent," including nongovernmental organizations in consultative status with the United Nations and U.N. organs such as the United Nations High Commissioner for Refugees, they can submit pertinent information to the Committee and be asked to advise on the optional implementation of the Convention.

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